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ABSTRACT

This guide is intended to assist caregivers of people with development disabilities in acquiring knowledge about sexuality and skill in expressing sexuality in a safe and appropriate manner. Section 1 provides an overview of the history of sexuality and developmentally disabled individuals. The second section provides exercises for the caregiver to evaluate his/her own knowledge and feelings about sexuality. The third section provides exercises to help caregivers empathize with the situation of residents in an institutional setting as well as guidelines for leading discussions with clients on interactions, dating, and the media. Four checklists for a successful human sexuality program are given next, covering: knowing your audience, evaluating clients' knowledge level, identifying program goals, and practical considerations. Guidelines for beginning a sexuality education program are presented in the fifth section. Next, activity sets offer suggested activities and materials for use with clients, addressing the following topics: (1) anatomy and physiology, (2) birth control, (3) pregnancy and parenting, (4) relationships, and (5) sexually transmitted diseases. An appendix presents a summary of facts about sexuality and covers pregnancy and birth control, sexually transmitted diseases, AIDS (Acquired Immune Deficiency Syndrome), homosexuality, and masturbation. A glossary defines 33 terms about sexuality. Contains 12 references. (DB)

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POSITIVE APPROACHES

A SEXUALITY GUIDE FOR TEACHING DEVELOPMENTALLY DISABLED PERSONS

By

LISA MAURER

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LISA MAURER

PREFACE

Getting accurate information about sexuality is not always easy, even as we enter the 1990s. For individuals with special needs, obtaining appropriate information in an easily understood format can be almost impossible. People with developmental disabilities need their caregivers to provide accurate information about sexuality in ways that are useful to them. The information contained in this guide will help caregivers to assist persons with developmental disabilities in acquiring knowledge and skills in understanding and expressing their individual sexuality in a safe and appropriate manner.

The purpose of this guide is twofold:

- To illustrate the inherent problematic nature of the history of this subject in general.
- To provide information to caregivers, parents and other interested individuals regarding sexuality education for persons with special needs.

Within this guide, information can be found on the what's, where's, why's, when's and how's of providing accurate, age-appropriate sexuality information to persons with special needs. The reader should note one important fact: when we attempt to separate sexuality from our lives, we ignore an integral part of that which makes us human. This compartmentalization, so often practiced with those who are developmentally disabled, is a tremendous disservice.

Because persons with developmental disabilities have long been devalued in many cultures, and, at best, considered asexual, resources in sexuality education for this population have been scarce. This guide presents an overview of the history of sexuality and developmentally disabled individuals, which illustrates the pressing need for such education. The background information is coupled with exercises, fact sheets and a variety of approaches to sexuality education for the developmentally disabled that we hope you, the reader, will find useful in your work with clients, family members or others with special needs.

FROM IGNORANCE TO ACTIVISM:

A BRIEF HISTORY OF DEVELOPMENTAL DISABILITY AND SEXUALITY

The history of society's attitudes toward persons with developmental disabilities does much to illuminate both the underlying attitudes toward diversity and disability as well as attitudes about sexuality in general.

EARLY HISTORY

One early reference to developmentally disabled individuals is found in a Greek text from 1552 B.C. Retarded people were referred to as "monsters" in this work (Evans, 1983). Later, in 900 B.C., Lycurgus, the Spartan lawgiver, attempted to assure that Sparta would be kept free of disabled people by mandating their deaths by drowning, abandonment, or being flung from cliffs (Evans, 1983). Time passed, and by 4 B.C. it became a popular practice among the privileged of Rome to "keep" developmentally disabled persons in their homes to entertain guests (Evans, 1983). During this period of time, the developmentally disabled person underwent the transformation from monster to jester, due to society's changes in perception.

People with developmental disabilities have been viewed from opposite extremes throughout history. During the Renaissance, it was believed that developmentally disabled people were able to communicate directly with God, while the Reformation labeled developmentally disabled people as satanically possessed. Their "demons" were exorcised through torture or death (Evans, 1983, 35-36).

The first medically oriented approach to the treatment of developmentally disabled persons was devised in 1614 by a physician named Montalto (Woolfson, 1984). In addition to Montalto's contribution, he also postulated that his patient's "overindulgence in sexual pleasure" actually caused the disability itself (Rowe & Savage, 1987, 6).

MODERN TRENDS

The Eugenics movement of the early part of this century sought to rid society of imperfect citizens through genetic engineering. Intellectual forces of the time

began to advocate proscriptions on marriage and childbearing for developmentally disabled individuals due to the fear of overburdening society with the care of disabled offspring. (Craft & Craft, 1983). Sterilization became popular as a major method of achieving this end. It would seem, however, that mass sterilization as a means of birth control was somewhat unnecessary, given the fact that segregation of the sexes was rigidly enforced in the institutions of the early part of the century.

During a fifty-year period spanning the late 1800s and early 1900s, one particular institution in the U.S. performed 656 castrations on clients in an attempt to stop, not procreation, but masturbation (Russell & Harding, 1980). Similarly, sterilization of women with developmental disabilities was frequently performed, not as a means of stemming the potential for disabled offspring, but as a means of eliminating the need for caregivers and/or developmentally disabled women to deal with their menstruation. It appears as though "custodial convenience" was the underlying factor in these sterilization decisions (Rowe & Savage, 1987, 7).

Legislation permitting the sterilization of persons with developmental disabilities became widespread in this country. Justice Oliver Wendell Holmes succinctly espoused the reasoning of the times in this judgment:

> It is better for all the world if, instead of waiting to execute degenerate offspring for crimes, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the fallopian tubes...three generations of imbeciles are enough.
> (Buck vs. Bell, 274 US 200, 1927)

The Mental Deficiency Act of 1913 was Congress' contribution in further legislating the lives of individuals with developmental disabilities. The Act made it illegal for such individuals to marry. The legacy of this legislation pervaded society to such an extent that fully one-quarter of the States still prohibited such marriages as late as 1972 (Chinn, Drew & Logan, 1975).

AN EMERGING ADVOCACY

Gradually, the beliefs that built up this framework restricting the sexual/social lives of persons with developmental disabilities were disputed and broken down. The idea of "routine" sterilization was challenged on many fronts, one of those being an aversion to the striking similarity it shared with the Nazi philosophy of creating a superior people by ridding society of "inferiors" (Rowe & Savage, 1987, 8). Still, many developmentally disabled individuals were "counseled" to agree to "voluntary" sterilization. Consequently, from 1945 to 1955, 75,000 voluntary sterilizations a year were performed nationwide (Bass, 1979). With laws supporting the notion that developmentally disabled people needed to be protected from society, and society protected from them, it is little wonder that this attitude prevailed (Bernstein, 1970).

Research, however, consistently showed that the ideas upon which these restrictions regarding marriage and reproduction were supposedly based were unfounded. Genetic data alone fails to support mandatory sterilization of all persons with developmental disabilities (Bernstein, 1970). Additionally, marriage is a highly important goal among this population (Edgerton, 1967), perhaps because of its portrayal by the media as being what all "normal" people do. Is it a case of society inspecting the lives of such people more carefully, looking for "problems to solve", when the bulk of society may do as it pleases? Wolfensberger elaborates on this subject:

> There are many nonretarded, physically healthy people who are sex-driven, shallow, incompetent, unstable, and incapable of deep, even of sustained relationships, yet our political system accords them the constitutional right to enter a legal marriage...Therefore, we should either apply more stringent criteria to <u>all</u> citizens, or cease applying them to the handicapped...
> (Wolfensberger, 1972, 172).

Concurrently, the notion that persons with developmental disabilities were either sex maniacs or asexual persisted. The Binet IQ test was originally designed specifically to separate the "regular" criminals from those considered "mentally

defective," many of them incarcerated for crimes of a sexual nature (Craft & Craft, 1983, 11). In fact, mentally retarded sex offenders account for a disproportionately low percentage of all such individuals, and the types of sexual offenses committed by them typically include behaviors such as "voyeurism, exhibitionism, or public masturbation" (Chinn, Drew & Logan, 1975, 254).

Advocacy groups promoting the rights of developmentally disabled people began to emerge in the 1950s; the National Association of Parents and Friends of Retarded Children (now the Association for Retarded Citizens) is the largest in the country (Evans, 1983). In 1954, the landmark Supreme Court decision Brown vs. the Board of Education, quite unintentionally strengthened the notion of providing the opportunity for equal education to all citizens, including disabled citizens (Evans, 1983). Consequently, the year 1956 marked the institution of coeducational school classes for developmentally disabled pupils (Rowe & Savage, 1987).

The 1960s brought issues facing developmentally disabled individuals and their families to the forefront of political consciousness, furthered by John F. Kennedy's overwhelming interest in this area (Rowe & Savage, 1987). A declaration of the rights of mentally handicapped people was written in 1968 at an international conference in Jerusalem, and was officially adopted by the United Nations in 1971. De-institutionalization, which began in the 1970's, began returning developmentally disabled individuals to the community, and the ever-existing need for comprehensive sexuality education became evident.

This considerable change in society's perception of the status of individuals with developmental disabilities appears to be due to two separately emerging trends of that time period. One was the so-called Sexual Revolution, with its corresponding effect on society's attitudes regarding the discussion of sexuality. The second influence was the Civil Rights movement, which, broadly viewed, advocated on behalf of many disenfranchised groups equal protection and services under the law (Craft & Craft, 1983).

But what of fears that the mere providing of sexuality education will "cause" sexual behavior? There is no evidence that sexuality education increases sexual activity. Specific to the developmentally disabled population, a study by Winifred Kempton (1978) showed that, of 430 students who had participated in her sexuality education program, there were no reports of any inappropriate behaviors in any of the students that could have resulted from the program. Staff working with these students did report positive behavioral changes, such as improved social interactions, increased self-esteem, and greater willingness to discuss sensitive issues openly (Kempton, 1978).

Over time, attitudes regarding individuals with developmental disabilities and attitudes regarding sexuality in general have been slow to change. Hopefully, progress will continue to be made on both of these fronts, leading to a better-informed society. Only then can caregivers and other interested friends help to provide the resources and support that persons with developmental disabilities require in learning about and expressing their individual sexuality, thereby obtaining society's permission to participate in the human experience.

Educating others about sexuality is a unique opportunity. It presents us with the challenge of first examining our own attitudes and beliefs about many major social issues. What does educating about sexuality have to do with our own beliefs, thoughts and feelings? The attitudes an educator brings through the door to a sexuality education program have an enormous influence on the attitudes and information his/her audience will have upon leaving. When dealing with an audience, especially one that may have had little exposure to information about sexuality, the educator may be perceived as an authority--an expert not only in terms of accurate information but also as a standard of what <u>everyone</u> should feel, think and do (or <u>NOT</u> do).

Thinking about our own sexuality can be confusing and threatening. Many of us received negative messages concerning sexuality from a very early age. Still others of us got no messages at all! The challenge, then, is to pass on positive, healthy information to our students, despite the fact that we ourselves may have been deprived of such information. Quite a formidable task!

How can we present information in a non-judgmental way after a lifetime of confusing, mixed messages about sexuality? The process of providing quality sexuality education for others begins, quite simply, with US. We need to examine our own values as a first step toward helping others form their own ideas about sexuality.

Following are a few exercises to help you start thinking about <u>your</u> attitudes about sexuality. Although all can be done individually, a group discussion of each exercise can usually enhance the activity for everyone.

EXERCISE 2.1: LEARNING ABOUT SEX

	How old were you?	Learned from whom?	How you felt?	Was info accurate?
Reproductive Anatomy of Own Sex				
Reproductive Anatomy of Opposite Sex				
Sexual Intercourse				
Birth Process/ Pregnancy				
Menstruation				
Wet Dreams				
Homosexuality				

EXERCISE 2.2: PERSONAL ATTITUDE INVENTORY

Read each statement and, based on your personal attitudes, circle the number that most accurately describes your true feeling about the statement.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1. Sex before marriage is wrong.	1	2	3	4	5
2. Sex education increases sexual activity in students.	1	2	3	4	5
3. Alcohol is good for sexuality.	1	2	3	4	5
4. Breast-feeding in public is inconsiderate of others.	1	2	3	4	5
5. It is difficult to get good information about sex.	1	2	3	4	5
6. Extramarital sex is wrong.	1	2	3	4	5
7. Communication between sexual partners is important.	1	2	3	4	5
8. Talking about birth control with your partner is unromantic.	1	2	3	4	5
9. Homosexuals are sick/ confused.	1	2	3	4	5
10. Masturbation is normal.	1	2	3	4	5
11. There is too much sexual activity on TV.	1	2	3	4	5
12. AIDS is the consequence of immoral behavior.	1	2	3	4	5
13. Sex without consent of both partners is wrong.	1	2	3	4	5
14. Old people have sexual thoughts, feelings and needs.	1	2	3	4	5
15. Parents are the best educators about sexuality for their children.	1	2	3	4	5

EXERCISE 2.3: LEVELS OF COMFORT

Everyone is comfortable discussing some things more than others. How do you feel about these topics? How do others--your partner, your friends, people in the community--feel about them?

Rate how comfortable you are with these issues using the scale of 1 to 5 below. Then note how comfortable you think others feel about the same topics.

(1) Positive (2) Fairly Comfortable (3) Neutral (4) Somewhat Uncomfortable (5) Intolerable

	Self	Partner	Friends	Community
Prostitution				
Disability				
Abortion				
Homosexuality				
Alcoholism				
IV Drug Use				
Premarital Sex				
Unsafe Sex				
Community Residences for Mentally Retarded Individuals				
Community Residences for Individuals Infected with HIV (the virus that causes AIDS)				

EXERCISE 2.4: SEX WORDS BRAINSTORM

Sometimes talking about sexuality is difficult for us because certain words or slang terms make us upset. Familiarity with these words may help us remember that a word means only what we want it to, nothing more.

Either in a group or alone, try to write down as many synonyms (technical and slang) for the following sexual/reproductive terms:

(Example: Testicles - balls, nuts, etc.)

Vagina	Penis	Menstruation	Intercourse
Breasts	Sexually-Transmitted Diseases	Masturbation	Homosexual
Heterosexual	Woman	Man	Date
Condom	Pregnant	Sexually-Active Male	Sexually-Active Female

EXERCISE 2.5: APPROPRIATE OR NOT?

Because of our role as teacher/caregiver, we may find ourselves in the position of judging whether engaging in certain behaviors is appropriate or acceptable for the individual(s) in our care.

Following are several situations. Would you allow an individual to behave as described or find the behavior not permissible?

	ACCEPTABLE	NOT ACCEPTABLE
1. Joe has convinced another resident in his group home to do all of his chores for him. Joe then informs staff that he has finished them.		
2. A client returns much earlier than expected from the market. She explains that others in line let her go to the front of the line when she told them she was retarded and had someone waiting for her in the car.		
3. A housemember brings home from work a package of construction paper that she wants to use for fun with her friends.		
4. A relative invites a resident of the group home to dinner. That client replies that he unfortunately has already made plans to have dinner with a neighborhood acquaintance. You know he has no such plans.		
5. Harold is enrapt in the Midnight Movie on TV. He explains the next morning that he wants to stay home from the workshop because he has a stomachache.		
6. Sarah accidentally sits on the record album she has just purchased. She returns it for a new one, saying it was broken when she opened it.		

How many "ACCEPTABLE" have your checked? Do not go on to the next page until you have completed this page!

EXERCISE 2.5 (CONTINUED)

Following are several scenarios. If you were in a similar situation, would you behave as described? Check whether these actions would be "acceptable" or "not acceptable" for you.

	ACCEPTABLE	NOT ACCEPTABLE
1. You are having dinner guests and need to pick up a few things from the store on the way home. You tell your boss you are not feeling well and would like to leave a little early.		
2. You see a long line at baggage check-in. You go to the head of the line and ask to be helped first, explaining that your plane is about to leave. Actually, your plane is not due for an hour, and you would like the extra time to relax in the coffee shop.		
3. You take a package of white paper from the office so the kids can make crayon drawings.		
4. Your mother-in-law calls and invites you to dinner. You are exhausted from a busy day and tell her that you have already made other plans for the evening (although you really have no plans.)		
5. You are up entertaining unexpected guests until 2:30 a.m. You call your boss the next morning and explain that you think you have caught the flu.		
6. While rearranging your den, you drop your new computer on the floor. You return it to the store and explain that you are very upset that you have purchased damaged equipment from their shop.		

How many "ACCEPTABLE" have you checked? How do these responses compare with the previous page?

It sometimes requires a closer look at what we judge appropriate for ourselves before we begin thinking about what is appropriate for others.

EXERCISE 2.6: WHAT IS APPROPRIATE?

How do we decide those behaviors which are appropriate for ourselves and others? It is sometimes necessary to examine our own situation and attitudes first, then take a moment to put ourselves into the other person's place before universally accepting or not accepting certain behaviors.

Consider the topics listed. Are they acceptable to you? Are they acceptable for others? Why?

	For Me	For Others	For a Developmentally Disabled Individual
EXAMPLE: Masturbation	Not acceptable	OK if partner is ill/away	primary, perhaps sole source of sexual expression
Dating			
Parenting			
Homosexuality			
Intercourse			
Marriage			
Oral Sex			
Premarital Sex			
Birth Control			
Sterilization			

SOCIALIZATION AND ACCEPTANCE

After examining our own attitudes and values, what next? Let's examine where sexuality education fits into the life of the developmentally disabled individual in the community. In order to do this, let's examine the following scenario. It will serve as a basis for considering several sexual/social issues that will be explored later in this chapter.

EXERCISE 3.1: TRADING PLACES

Answer the questions that follow each section of the following story.

Imagine that for as long as you can remember, you have been living in a single-sex dormitory with a large number of other people. You have lived with many of these people since childhood. There are several caregivers for everyone in the dormitories, and they are present at all times. Sleeping, showering and eating are done with the group. There are no separate bedrooms for anyone, but instead a large room that houses a bed and dresser for each resident. In fact, you have no concept of what a "private" place is since you are nearly always in the company of other dorm residents and caregivers.

1. Write down 3 questions you might have about sexuality and reproduction.

2. Who might you ask for answers to these questions?

3. How accurate would these answers be?

Exercise 3.1 (Continued)

One day you learn that you will be moving away from this environment to a very different one. It is a home in a neighborhood quite a drive from the dorm you have lived in since childhood. The house has four bedrooms, and only a few others will share the house with you. Here, everyone has his/her own private space, as well as public space he/she can share with other residents. There will still be caregivers to assist you in caring for yourself and your new home.

Weekdays, you will ride to a sheltered workshop. A van will pick you up in the morning and drop you off at your driveway at night. Everyone who rides the van works at the workshop with you. It is very interesting to meet all of these people. Some are familiar--you remember them from where you lived before. Others are people you have never met before. One very striking difference that you notice is that at work, as well as in your neighborhood, nothing is sex-segregated. You work, eat lunch and ride the van side-by-side with both men and women.

4. What new questions might you have about sexuality?

5. What are some of the possible reactions of your caregivers if you brought your questions to them?

6. How accurate would the information be that you might get from your peers?

Exercise 3.1 (Continued)

You have much more interaction with the community than you had before. You and your housemates participate in shopping for groceries and personal items, locate local restaurants and other services, and also have the opportunity to participate in social activities sponsored by your workshop and other community organizations. Dances, trips and dinners out are some of the activities that are now part of your social calendar. Almost always, your housemates and acquaintances from work also attend these functions.

7. How do you learn about appropriate behavior in the community and at social events?

8. How might you meet possible partners? How does this compare to your previous environment?

9. How might you handle these new experiences?

After a while the interesting variety of this new life begins to wear thin. You and your housemates sometimes experience friction in going about your day to day routine. You have made some friends at work, although now you realize that rarely will you meet anyone new there. You and your housemates live together, ride the van together, work at the same workshop together and go to practically the same social functions together, along with the same people from work. After a while, this exciting new life seems rather boring.

Exercise 3.1 (Continued)

10. How do you deal with spending so much time with your housemates?

11. Where can you go for time away from other housemates and work acquaintances?

12. What kind of partner selection do you have? How do you feel about this?

* * * * * * * * *

DEVELOPING SOCIALIZATION SKILLS

Although the previous story is fictitious, it contains some (or sometimes many) elements common to the experiences of many of the developmentally disabled adults we know. As with any generalization, some (or sometimes all) of those elements may not apply to any particular person, depending upon his or her circumstances. For example, there will be a growing population of young people we serve that may have spent little or no time at all in any type of institution. Still, with the emphasis on deinstitutionalization and normalization, many adults now in community residences have spent a major portion of their lives in an institution, in an environment usually very unlike that of the community at large.

As in the example story, many people have been institutionalized from childhood with little if any recollection of any other type of social or family setting. We must remember that a 69-year-old man institutionalized from infancy until his placement recently in a community residence, a 30-year-old woman institutionalized from age 11 to the present and a 21-year-old person raised by family until the opportunity for living independently in the community presented itself have very different life experiences from each other. They also have varying degrees of mastery of the basic concepts we may only assume they understand. Appropriate social and sexual concepts are vital for a background to sexuality education. How then, do we begin?

We need to start by realizing that although our own sexuality education might have supplied us with little or no factual information, compared to a person whose whole life experience has been within the framework of an institutional setting, it certainly has been different. Some concepts, which we assume everyone understands, may mean nothing (or something quite different) to someone whose opportunities for socialization with others have been limited.

PRIVACY

Everyone knows what is meant by a public place versus a private place, right? Wrong. What are the private places? Are they places like bathrooms and bedrooms? What if you live in a dormitory-style room with 10 or 15 beds in a large room and a communal bathroom area? What if you have a more traditional bedroom but with a roommate? If we explain that a private place is an area where we are alone, will that do?

I worked with a client who, when asked to please masturbate in a private place instead of the group-home living room, explained, as though exasperated with having to point out an obvious fact to me, "This is a private place--no one is here [in the living room]. Everyone else is in the dining room" [which adjoined the living room]. For this person, simply saying that a private place is one where you are "alone" could potentially mean many places: a sitting room in the house while others are elsewhere, a chair on the front porch, a bathroom stall at work, the dining area at McDonald's during a between-meal-hours slump, etc. When people have limited opportunity to be "all by themselves" in an area that few others have a need to be in or nearby, it is unfair to use this description of privacy. In this case, a more balanced, descriptive definition of privacy might be "alone in your bedroom with the door closed" or "in the bathroom with the door closed."

RELATIONSHIPS

Relationships can be another confusing or complex area. It is important to recognize that for some developmentally disabled individuals (as well as for some people who are not developmentally disabled), identifying and discussing the relationships they have may require extra sensitivity. Some people may be unable to list relationships they have because many of the traditional figures we think of (mother, father, siblings) may have been absent or uninvolved in their lives. Perhaps the only consistent caring figure in their lives is a particular staff person who has been there for a while. In such situations, it may be a good idea to examine these issues. Yes, for some people, thinking of Mom or Dad or Uncle Bert may bring to the

surface feelings of sadness or hurt or anger. For others, emptiness may be the overwhelming feeling. It may help once again to stress similarities between their experience and those of their friends, or bring in our own experiences. Some people whether developmentally disabled or not do have uninvolved (or even abusive) families. Some people have a wealth of companionship with the family at holidays. No one is a bad person, whether they have had the benefit of a caring configuration of relationships in the past or not. What we <u>can</u> do is build and improve skills for finding and nurturing their current relations in order to construct the kind of support network they want and need.

<u>EXPRESSION OF FEELINGS</u>

Appropriately expressing feelings within the context of relationships also needs to be discussed. If a developmentally disabled person "likes" a particular staff person, is it appropriate to kiss that person or ask him or her out on a date? The people we serve need to know how to express themselves in realistic, age-appropriate ways. Although (as alluded to in the story that began this chapter) partner selection for developmentally disabled individuals may be somewhat more limited than for others, it is necessary for all adults to recognize the types of relationships they have and appropriate ways to express feelings. Do we hug and kiss the grocery clerk for ringing up our order? Do we give the librarian a big bear hug? Do we give co-workers flowers and candy every day we see them because we are friendly? These may seem to be easily answered until viewed in terms of the person who is unaware or unskilled at recognizing different levels of relationships. The developmentally disabled individual in our care may wonder: If a staff person holds my hand to cross the street, does that imply love? Caring? Do other adults hold hands when crossing the street? When? Why? Because staff people frequently experience my life, my joy and my sorrow with me, should that then mean that I should feel hurt if not invited into <u>their</u> lives (for parties, social activities or dinner)?

When discussing the expression of feelings, we need also to be clear about love relationships--about those who are appropriate partners (co-workers, social contacts, etc.) and those who are definitely not (children, professionals assisting them, etc.) We must not only clarify when to show affection, as mentioned above, but also how to show affection. It may be very appropriate to greet casual acquaintances with a big hug and kiss if they have returned after a long absence, if they are to be our new in-law, or if they have recently survived a gigantic plane wreck or natural disaster. This may seem obvious at first, but it is certainly a very abstract idea. We must help developmentally disabled individuals to develop the skills to make these types of judgments with confidence, while acknowledging that many developmentally disabled people live in very concrete worlds.

EXERCISE 3.2: INTERACTING WITH OTHERS

The following questions are useful in a discussion designed to help developmentally disabled individuals understand that people behave in different ways in different settings.

1. How do we show affection? To whom? Where?

2. Does everyone feel comfortable kissing a partner in public? What reasons might someone have for not wanting to show affection in public?

3. Why do some people feel comfortable at home with a partner wearing little or no clothing? Why do others feel differently?

4. Is the outlandish or revealing clothing worn by rock stars on MTV appropriate for everyone? Will wearing that type of clothing attract suitable partners?

As you can see, it can be quite a challenge to portray the diversity of opinion and behavior, which we see around us, to developmentally disabled people, while concurrently supplying them with information they can use immediately in their own lives.

* * * * * * * * *

DATING

As illustrated by the opening story, many developmentally disabled people have had little or no opportunity to learn the social behaviors most of us acquire throughout our lives. Because they have limited opportunities for social interactions with others (especially of the opposite sex), discussions of relationships and dating may have to be very basic. Where might you meet potential partners? How do you convey your interest in a potential mate? What are things that partners do together? How do they decide whether or not they should date (or continue to date)? For someone who has never had the opportunity to do so before, dating can be a confusing experience. In addition, this will frequently involve a person convinced that he/she wants to date but does not know how to go about it, or a person who does but is dismayed by the apparent lack of variety in the appropriate potential partners in his/her life. Once again, sensitivity is called for, as well as a certain willingness to talk about things that may seem obvious to you. Remember--although many people may choose not to engage in such behaviors--most adults are quite free to start a conversation with an attractive person in the supermarket, to frequent singles' clubs in search of partners, or even to engage in anonymous sex. For adults who are constantly supervised, all of the aforementioned partner-seeking activities may be off-limits.

EXERCISE 3.3: DATING

A discussion of dating can assist developmentally disabled adolescents and adults in acquiring the skills they may have had little opportunity to develop thus far. The following discussion guidelines can be used to help individuals understand the steps that lead to dating.

1. Where do you meet people? (Dances, work, other social activities...)

2. How do you get to know someone? (Introduce oneself, find common interests, enjoy lunch at work together, invite home for dinner...)

3. What do partners do? (Spend time together, go to movies, share thoughts and feelings...)

For people who are interested in becoming sexually active, the discussion broadens. Why do people have intercourse? What about disease? Pregnancy? Are both partners ready and willing to become parents? Is it easy to be a parent, especially if you still need help from others with your daily routine? How can you tell if both partners are ready for sex?

* * * * * * * * *

ACCEPTING SEXUALITY

In order to make healthy, responsible choices about the expression of their sexuality, people need the facts--about pregnancy, sexually transmitted diseases, AIDS, birth control, etc. For some, this may mean a realization that parenting may never be a possibility, or that masturbation may be the primary means of sexual expression until a suitable partner is located. These choices, too, are healthy and responsible. Many people, whether disabled or not, make these types of decisions every day. There is nothing wrong with pointing out that many people may choose to abstain, to masturbate or to decide they are not at all interested in parenting. In fact, stating these ideas is another vital part of providing balanced, factual information about human sexuality.

SEXUALITY AND THE MEDIA

In this age of media bombardment, everyone (especially developmentally disabled adults) sometimes feels as if everyone else is happy, fulfilled and paired with a stunning, intelligent, wealthy partner (or partners), based on the images seen on TV. Because of this perception, many people experience loneliness and depression due to their perceived inability to attain such things in their lives.

On television, even the most difficult life crises are tackled and usually surmounted within the space of 30 to 60 minutes (minus commercials). Even commercials pair beautiful women with beautiful new cars and promise sensual relationships if you choose a particular toothpaste or mouthwash. Now, "900" numbers provide sexual fantasies for paying callers. Against this media backdrop, communicating about accurate expectations can be difficult.

EXERCISE 3.4: MEDIA IMAGES VS. REALITY

Finding teachable moments based on TV shows or characters may assist in putting things into a more realistic perspective. The following are suggestions for beginning a dialogue.

1. Daytime or evening soap operas are full of opportunities for discussions about relationships. Point out examples of situations in soap operas that would not be likely to happen in real life. A discussion starter might be "What do you think about how the character handled that situation?"; "Would you have done something differently?"; "What are some other possible outcomes for that character, even if he did exactly the same thing?"; "Do you think this program accurately shows what it is like in most people's lives?"

2. Some shows are entertaining because the situations shown, or the very premises upon which they are based, are pure fantasy. Although they are obvious to many viewers, the developmentally disabled person may take them literally. Questions such as the following may lead to an understanding of how unreal these situations are. Is there such a thing as a talking car that can operate itself? Do you think that character would have nearly as many adventures without it? Can a person travel through time? Do you think a real cruise ship has these kinds of things happen aboard? Do you know anyone who has ever been on a cruise, or worked as a private detective, or gone through medical school in nine weeks?

3. Even commercials can be a springboard not only for discussions about human sexuality, but also as a means of defining the boundaries between reality and fantasy. A positive by-product of such a discussion might also be a wiser consumer. Do products always do exactly what commercials say they do? Why? If you buy that brand will it really make you dance and sing as you clean your kitchen with it? Will it match you up with exactly the perfect romantic partner? Why do advertisers show these unrealistic things?

So much of what television has to offer is riddled with confusing and often contradictory messages, especially regarding sexuality. It is important to stress that TV does not always mirror real life. It is just as important then to point out examples of particularly accurate portrayals of real life, when they occur on the screen. This type of contrast may further the group's understanding of the line between reality and fantasy, and they may then be better equipped to set their own goals and make their own choices within the oftentimes less overwhelming, less narrowly focused spectrum of the possible.

* * * * * * * * *

OPPORTUNITIES FOR EXPRESSION

Another area that may require sensitivity involves those people who are sexually active and lack ample time or appropriate location for such activity. Once again, individuals who are constantly supervised certainly have little opportunity for sexual activity and therefore may resort to sexual activity with lightning speed or in inappropriate locations (for example, behind some bushes or in the broom closet at work). It is important to avoid overreaction to these situations. Did the person involved do it to get himself/herself suspended for a period of time from work, or simply because he/she could not find any "acceptable" alternative? Although developmentally disabled individuals have the right to express their sexuality, there are frequently rules and regulations regarding the appropriate time and place for such expressions simply by virtue of their living arrangements. The opportunity to stay home from work one day for quality time with one's partner, or to invite a lover home after a date, or to have sexual intercourse on the kitchen floor might be open to many people (although they may also choose not to do so). For someone living in a group environment with 24-hour supervision, none of these options may be acceptable.

SEXUAL ORIENTATION

Sexual orientation is a final issue for careful consideration in this section. As described in the opening story, many developmentally disabled individuals come to us with a long history of living in single-sex institutions. "Institutional homosexuality" is a phrase that is often used to describe the effect such a life can have on a person with no other opportunity for opposite sex partners or for someone who, because of the environment, perceives that same-sex partners are appropriate. Indeed, some same-sex relationships have been encouraged in the distant past because of the "convenience" of not having to worry about the possibility of pregnancy. The possibility of sexual abuse or exploitation of developmentally disabled individuals by

others must also be taken into account. Along with these, however, we must be cautious about assuming that any behavior that appears to be homosexual must certainly be a direct result of these (usually) institutional occurrences. Some developmentally disabled people are gay or lesbian, just as some people, who are not developmentally disabled, are gay or lesbian. To label all developmentally disabled people heterosexual, given the "right" upbringing, is to do a tremendous disservice to those whose sexual orientation actually is not heterosexual. Once again, this is a difficult area for discussion. It necessitates an understanding of society's reactions to homosexuality (such as homophobia), and affirming messages and information about support for homosexuals' status as a sexual minority. Although it is an unfortunate reality in our culture, we must be specific about the consequences that openly homosexual displays of affection may bring upon people in public settings like a bus stop, restaurant, or park. In any case, there are resources both to assist those who may have had a homosexual experience as the result of abuse or exploitation, and those who regard themselves as sexual minorities or question their sexual orientation.

The task before you now is to design a program in human sexuality. Many questions may spring to mind: Who is your audience? What do they know already? What do they want to know?

What are the primary goals of the program? How will its success be evaluated? What materials, if any, will be available. What materials should be prepared in advance?

For parents, many of the answers may be obvious. For direct-care staff, also, some answers may be readily apparent. In both situations, the opportunity exists for long-term, trusted communication and learning to develop over time. For educators who do not have daily contact with the individuals they will be working with, it is often advantageous to have as many as possible of these background questions answered before the program begins. Preferably, the answers should be supplied by the direct care-givers and/or the developmentally disabled individuals themselves.

It will be helpful to use experience as your guide. It is not necessary (or even possible) to know everything there is to know about your audience. However, the more you know, the more relevant your program is for the participants, and the more likely they are to have an increased awareness of their sexuality and reproductive health and to learn ways in which they can enjoy and preserve that good health.

The rest of this chapter contains checklists to help you get organized. Not every question may be anticipated or answered in advance. However, the more you understand your audience, the more you are able to prepare your program to be as relevant, understandable and personalized as possible. Success in aiding the members of your group in understanding and expressing their unique sexualities in safe, healthy, appropriate ways may depend on the advance preparation that you are able to do.

The following list contains questions which will help you tailor your presentation to the needs of the group.

CHECKLIST #1: WHO IS YOUR AUDIENCE?

1. What is the age range of your audience?
2. Where have they previously lived? (In an institution, with family, independently...?)
3. Are they verbal or non-verbal?
4. Can they easily understand others? Can others easily understand them?
5. Do they use signs? Are these standard signs, or a more personal set of signs they have adapted themselves?
6. Are they visually and/or hearing impaired?
7. Might it be possible to meet or observe the group in advance?
8. Are there any other important details or characteristics about the group that may affect what material or what techniques you use?
9. How many people will be in your group?
10. Is the group mixed or single-sex?
11. What level of social skills does the group have?
12. How much access to the community do they have?
13. What day or work programs are they involved in?

The following questions should be asked in order to understand the background of the group and ascertain what information they have already received about sexuality. Sexuality educators are often invited in as a response to a problem. If this is the case, you must evaluate your own expertise and training and decide whether you are the right person for the job.

CHECKLIST #2: WHAT DOES YOUR AUDIENCE REALLY KNOW?

1. Are they asking questions about reproduction and/or sexuality?

2. Have they had difficulty in appropriately expressing their sexuality?

3. Has a program in sexuality been suggested because of, or in an attempt to, eliminate questions or problems? (If so, a training or in-service program for the staff might be appropriate.)

4. Is your audience dating or interested in dating?

5. Is anyone married or have they been in the past?

6. Is anyone a parent?

7. Has anyone had a course in human sexuality before? If so, what type of program/information was it?

Understanding exactly what the expectations are and how all involved will evaluate its success is vital to presenting a meaningful program.

CHECKLIST #3: WHAT ARE THE GOALS OF THE PROGRAM?

1. What does your audience want to know?

2. What does the agency or the individual requesting the program want your audience to learn?

3. What are your goals for a successful program?

4. Which will be most useful: A sexuality educator to provide information, or a behavior modification specialist to help alleviate or eliminate inappropriate or dysfunctional behaviors displayed by an individual?

5. How will the program be evaluated by the party requesting the program? By you? By the participants?

6. How useful is the material presented to the group? Is it age-appropriate? Does it aid in everyone's understanding and expression of his or her unique sexuality?

Educators frequently work in a variety of locales, with resources ranging from the latest modern equipment to none at all. Asking what is available before you arrive can eliminate some nasty surprises. If a videotape is an integral part of your usual presentation, it helps to know whether a VCR is available. Knowing ahead of time where you need to be and what you will find there can go a long way toward helping you feel confident about making your presentation.

CHECKLIST #4: PRACTICAL CONSIDERATIONS

1. Where is the program site? For whom should you ask, or where should you go upon arrival at the site?

2. When will the program take place? Is this a time usually reserved for other activities (dinner, laundry, etc.)?

3. Has the direct-care staff been notified? How do they feel about the program?

4. Do you need any special equipment or supplies that may be furnished at the program site (VCR, chalkboard, etc.)?

5. How much time is allotted for the program? Is it adequate to accomplish your goals?

6. Is the schedule realistic for both you and the participants?

7. Have any participants traveled a long distance to attend, or have you?

8. Has the program schedule significantly disrupted the lives of the participants, the care-givers or yourself?

9. Are there any important agency policies regarding socializing or sexuality that you should be aware of before implementing your program?

10. Are there other people who must be notified or who must give consent before the program can proceed?

For educators who conduct programs with many different individuals, it may be helpful to record important information about the groups you work with. The following format, or one similar to it, may be suitable for your needs.

SAMPLE PROGRAM REQUEST RECORD

Date of Request _____

Program Date _____ Program Time _____

Contact Person _____

Agency _____

Address _____

_____ Phone _____

Type of Program(s) _____

No. of Participants _____ Male _____ Female

TV/VCR available? _____

Program Location and Directions:

Additional Comments:

****************************Upon Program Completion*************************

Participants' Names (if a letter documenting participation is requested)

Date/Time of Next Program _____

Notes:

READY TO BEGIN

CONDUCTING THE PROGRAM

When a person is introduced as a "sexuality educator," whether to a group of people who are developmentally disabled or not, frequently the participants already have questions and comments they have been storing up, waiting for such an opportunity to appear. If the questions are numerous and relevant to the subject, go ahead and let them be your guide for conducting the program. Remember that the information you provide must be understandable and appropriate for the participants in order for them to pay attention and to begin to incorporate it into their daily lives. Have you ever found yourself in a situation that you (or others) have important questions regarding how the presented information may fit into your life, yet the presenter relentlessly plugs through a sterile, prepared outline, oblivious to the idea that what is presented must be in a context which the audience can use? For instance, a basic program in anatomy and physiology would have a very different focus for an audience of pre-pubescent girls than for a group of older women.

WORKING WITH SOMEONE YOU KNOW

For people who are primary care-givers or parents, your everyday contact with your audience is invaluable. By beginning and maintaining a strong, trusting communication base, events in day-to-day life may form the core of a sexuality education program. Questions may arise during TV shows, in the supermarket, or as a result of any number of things that happen in the course of a day. Be aware of these kinds of "teachable" moments, and take advantage of them as opportunities for sharing facts and feelings. Because of your unique position in daily personal contact, you can answer questions as they come up, utilizing them as a springboard for discussion. You may be in a better position to gauge exactly what is being asked, why, and in what manner the question might best be answered. In addition, never be afraid to admit that you may not know the answer--researching the answer

together not only provides information for both of you but also demonstrates how and where to find the information.

WORKING WITH A GROUP YOU HAVE JUST MET

For educators who do not have an already existing foundation of trusted communication with their audience, there are a number of ways in which this can be nurtured. Frequently, merely being introduced as a sexuality educator will earn some degree of immediate trust, but there are a number of additional techniques you can employ right away to help earn or keep the trust of your audience. This is very important, as an audience may not be as open, or even interested, if they feel the situation is threatening or not confidential.

Introduce yourself and ask everyone else to introduce themselves. Tell everyone a little about what you do and ask them a little about what they do. Make sure everyone (including yourself) feels comfortable physically--learning is much more difficult when people are tired, hungry, too hot or too cold or there is inadequate space in the room for everyone to be seated comfortably. Additionally, if you are not comfortable physically, your expression or manner may broadcast this fact to the audience--an audience who senses your distress may interpret it as a sign that you are not comfortable with the subject matter (or with them)--and may discount everything you say.

In addition, do not SHOUT -- unless your audience is hearing impaired and needs you to speak in a raised voice. Talking more loudly will not aid in conveying your message. Some people think that developmentally disabled people can be "made" to understand if you shout rather than take more time to repeat or rephrase. Have you ever been in a situation where others tried to "shout" a message into understanding (perhaps as a visitor to another country or even a distant part of this country)? Use a normal, conversational tone. You do not want to risk offending your audience or having them "tune you out" as they may have learned to do in other noisy situations.

TELEVISION AND MAGAZINES -- HANDY RESOURCES

As alluded to previously, most developmentally disabled individuals live in a very concrete world. When planning the program, this should be kept in mind as a positive guide rather than an annoying hindrance. Nowhere is this more apparent than when dealing with what people learn from television. Television can have a very large impact on one's beliefs about the world. For some people (disabled or not), television is seen as reality. Unfortunately, TV is not as accurate a reflection of real life as it appears. However, these facts can be used to our advantage in discussing sexuality.

I once met with a group of developmentally disabled adults who told me they knew about the "risk groups" for AIDS infection. When I asked them to tell me about risk, they told me that "skinny white men" are the only people who have to worry, and that they in fact needed to worry a lot because every time any of the group had ever seen a skinny white man on TV he had AIDS! It took a lot of discussion about AIDS, TV and reality before I was able to convince them that there were lots of people who were not "skinny white men" who contracted the HIV virus. "Then why don't we see them on TV?," asked one of the participants. The answer to that question is a discussion in itself, difficult for anyone to ponder or acknowledge. For a developmentally disabled audience, it may be helpful to ask how many times they may have seen a group home or sheltered workshop on TV, or even any type of disabled person portrayed at all! Recently there has been a trend toward some awareness that everyone in the real world is not svelte, blonde and from California; but still, accurate portrayals of developmentally disabled persons remain the realm of a few television series.

With this in mind, try to think of the media's portrayal of sexuality--do our favorite characters suddenly find themselves pregnant or infected with a sexually transmitted disease after a long-awaited affair is consummated? All the more difficult, then, to explain and discuss the chance of such occurrences in the real world. Some people may even become hostile if it is suggested that life is just not the same, easily-solved-problems-in-30-minutes world that we see on TV!

We can, however, use television to our advantage. It may be easier for participants to role-play or discuss "what if" scenarios involving favorite TV characters than for them to talk about their own lives.

Likewise, utilizing colorful magazine pictures can start or revitalize a conversation about relationships or social behavior. It may take a bit of advance preparation, but having several plans for a particular topic may be much more effective, yielding one or two approaches that work best for each particular audience.

ENLISTING THE AID OF FAMILY OR STAFF

One final word before delving into the material is the all-important area of referring a program participant for information or treatment for a reproductive health concern. As mentioned earlier, everyone needs accurate information and also the tools to get more help or information when needed. This may mean, for some developmentally disabled people, the name and location of the nearest clinic, the public transportation route to take, the way to alert direct-care workers to the need for additional services, etc. Where is the nearest wheelchair-accessible facility that can render services? Is there anyone on the staff that can answer any questions specific to the person's particular disabilities and abilities? Will the staff feel comfortable dealing with a patient who is disabled? This is an area where a friend, direct-care staff person or family member can serve as an invaluable liaison between health care provider and the person needing services. Explaining the examination procedure beforehand may be essential, as well as talking about any extenuating circumstances (the likelihood of protesters at a clinic, for example).

The following exercises can help in planning a program on human sexuality and they can be modified to suit the audience and setting. Several of them are accompanied by sample questions and answers that can come up in your presentation or that you can use to facilitate discussion. Good luck!

ACTIVITY SET #1: TEACHING ABOUT ANATOMY AND PHYSIOLOGY

There are many different approaches to use when discussing anatomy and physiology. Here are a few suggestions:

Audiences with basic knowledge about the differences and similarities between men and women may be interested in explanations of the functions of the reproductive systems. Flip charts or diagrams are useful aids. An audience at this level can consider various birth-control methods and discuss how they work and how to use them correctly.

A. Teaching Anatomy and Physiology to a Higher-Functioning Group

Materials Needed: Flip chart or diagrams of the male and female reproductive systems.

1. It is usually best to start with a chart or diagram showing the location of the reproductive systems in the male and female. A drawing showing a person from the outside, with the reproductive organs highlighted or otherwise made visible, is a good starting point. You may need to stress that real people have these organs, or some of the organs that are highlighted inside the body where they cannot be seen as they are on the charts. Take time to explain the view shown on your diagrams. You may need to ask your audience questions to see if they understand the diagram (eg.: can you see these organs when you look in the mirror (for females)?; if we had X-ray glasses, could we?; these pictures show organs in blue and green--are they really those colors in real life?). Use your own body to illustrate--"this is a picture of a woman standing sideways as I am now."

Sample Questions and Answers

- Can the female reproductive system be seen on the outside of the body, even if the woman has her clothes off?

  The female reproductive system is located on the inside of the body, with the vagina leading from the reproductive organs to the outside. The vagina is the path a baby takes from the uterus when it is being born.

- What parts of the male reproductive system can be seen on the outside of the body? Is there more on the inside of the body where it cannot be seen?

  Men can see most of their reproductive system just by looking. The penis and the testicles are located on the outside of the body. The testicles are enclosed in a sack of skin called the scrotum, which protects them. The scrotum has a very special job: it has to keep the sperm in the testicles at the same temperature all the time. It does this by raising and lowering the testicles, pulling them close to the body if they get too cold, and lowering them away from the body when they need to cool down. There are other parts of the male reproductive system located inside the body that help the sperm make the trip from the testicles to the outside.

- Why do men and women have reproductive systems?

  The purpose of the reproductive systems is to produce babies. Men are built so that they can make sperm and pass it on to a woman when the couple want to have a baby. Women are built differently so that they can provide both an egg to be fertilized by the man's sperm and also provide a place for the baby to grow while it is getting ready to be born. Parts of the reproductive system (the penis in men and the vagina and clitoris in women) are very sensitive and feel good when touched, so another reason we have these organs is for sexual

pleasure. Sometimes people like to touch these parts of their bodies when they are alone and in private, which is also OK. Other people do not like the idea of doing this, which is also OK. People who love each other and decide together that they want to have a sexual relationship may also receive pleasure from touching each other in these places. When men and women are sexual partners, they may decide to have intercourse, which can lead to having a baby.

- Why do women have breasts?

At puberty, which is sometime around the age of twelve for most people, girls begin to develop breasts. If they decide to have a baby when they are older, they will be able to make milk for the baby. After a baby is born the mother's breasts will fill with milk that the baby can drink if the mother decides to nurse. Since men do not have babies, they do not need to have breasts that can store milk.

2. Turn to a chart or diagram showing the male reproductive system. Explain how and why an erection happens. Trace the path of the sperm from production in the testicles, through the vas deferens, to the formation of semen, to ejaculation from the penis.

<u>Sample Questions and Answers</u>

- What are sperm? Why do men have them?

It takes a special tiny cell from a man and a special tiny cell from a woman, joined together, to make a baby. The woman's cell is called an ovum, or egg and the man's cell is called a sperm. When a sperm and an egg join together, they begin to divide and make more cells. This happens over and over; the bundle of cells grow larger and larger, and after a while, eyes and ears and

hands and feet, and all the other parts of a human being develop. At the end of nine months, what started out as a one-egg cell and a one-sperm cell has grown into a baby ready to be born.

- Where are the sperm made?

Sperm are made in the testicles. After the cell is produced, it travels through a long tube located alongside the testicle called the epididymis; it takes about two weeks for the sperm to make this trip. At the end of two weeks, the sperm is mature, or ripe, and ready to fertilize an egg.

- How do sperm leave a man's body?

Sperm leave a man's body in reaction to touching or stimulating the penis in a sexual way. When a man is sexually stimulated, his penis fills with blood and becomes hard and stiff; this is called having an erection. If the man continues to be sexually stimulated, his sperm will move along the vas deferens until it reaches the prostate gland where it mixes with fluids from the seminal vesicles and the prostate. This mixture of sperm, seminal fluid and prostate fluid is called semen. With continued sexual stimulation or touching the penis, the prostate gland will contract, forcing the semen out of the prostate gland and out of the end of the penis. This is called ejaculating; it is often accompanied by a very pleasurable feeling called orgasm.

- Does sperm have to come out if erection occurs? What happens to it if it does not come out?

Just because a man has an erection does not mean he has to ejaculate. If a man does not ejaculate, eventually his penis will lose its erection and become soft again. He does not have to worry about building up too much sperm in

his testicles; if the sperm are not used, after a while they die off and are absorbed by the body, just like any other cell in the body.

- What is masturbation? Is it wrong?

Masturbation involves a person touching or stimulating his or her own sexual organs in order to get the pleasant feelings that occur. Sometimes people touch these parts of their bodies until orgasm occurs. For a man, this is when semen comes out of his penis. For a woman, masturbation involves touching the clitoris or the area around the clitoris in a way that feels pleasant. Orgasm is often described by women as a series of contractions of the vagina that feel very pleasurable. No harm can come from masturbation, and people should not be worried that they do it "too much," nor should they worry if they do not do it at all. Masturbation is a matter of individual choice; each person must decide if it is right for him or her. It is a private decision.

- When does the male reproductive system begin to make sperm? Does it ever stop?

Most men begin to make sperm at around the age of 13. Their testicles will continue to make sperm around the clock for the rest of their lives. A man does not become "too old" to make sperm. So a man is physically able to become a father from the time he reaches puberty until he dies.

3. Turn to a chart or diagram showing the female reproductive system. Explain the menstrual cycle: describe the build-up of blood and tissues in the uterus; trace the path of the egg from the ovary, through the fallopian tube and into the uterus; explain the shedding of the uterine lining through the vagina.

Then explain how the process is different if a sperm cell meets the egg; trace the steps of a pregnancy.

Sample Questions and Answers

- Why does the uterus need a special lining? How long does the menstrual cycle take?

  The uterus builds up its lining every month because every month it expects an ovary to release an egg that will meet up with a sperm, thus causing pregnancy. The lining is there to provide a safe, warm place for the baby to grow. It takes about 28 days for most women to build up a lining in the uterus, release an egg, and then shed the lining if the egg is not fertilized. (Some women have shorter cycles and others' are longer than the average of 28 days.)

- How long does it take for the egg to travel from the ovary to the uterus? What happens to it if it does not meet a sperm cell? What happens if it does?

  It takes the egg about two days to make the trip from the ovary to the uterus. If it meets a sperm while it is making this trip through the fallopian tube, the egg and sperm will join together and the woman becomes pregnant. If it does not meet a sperm cell by the time it reaches the uterus, it will dissolve and leave the body when the woman has her period. If the egg is not fertilized, the uterus gets rid of the special lining because there is no baby to support. This cycle happens over and over to all women until another special time called menopause.

- How big is the egg? Is it like a chicken egg?

The egg is really just a single cell. It is so tiny that it is about the same size as one grain of sand. If you could go to the beach and pick up just one piece of sand, that is the size of an egg cell inside a woman's body. There are thousands and thousands of these tiny eggs inside every woman's ovaries.

- How does sperm get inside a woman? Can a woman make her own sperm cells, or does she have to get them from somebody else?

Since sperm are made by the male reproductive system, a woman has to get them from a man; she cannot provide her own! Sperm are usually passed on to a woman when a man ejaculates inside the woman's vagina after placing his penis there during the act of sexual intercourse; however, sometimes sperm can make its way into the vagina if it is deposited on or near the outside of the vagina, so it is not always necessary to have intercourse for a sperm to enter a woman's vagina. This is why a couple who is not ready to be parents have to be very careful to make sure that sperm and egg do not have a chance to meet up, either by not having sex, or by using a good birth-control method.

- Does a woman continue to have her period when she is pregnant? Why not?

A woman sheds the lining of the uterus each month during her period because she has not gotten pregnant. When another egg is released the next month, her uterus needs a new, fresh lining so she has to get rid of the old one. When she becomes pregnant the lining does its job of providing a safe place for the baby to grow, which it will continue to do during the whole nine months that the baby spends inside its mother's uterus. So a woman's periods stop while she is pregnant, since the lining she built up to receive the fertilized egg is doing the job it was meant to do. After she has a baby, the uterus

begins building up a lining every month, over and over as before, so she can have more babies if she wants.

- Does a woman make eggs all the time the way men make sperm?

Women are born with all the egg cells they will need for the rest of their lives ready and waiting in their ovaries. At around the age of 12, the ovaries begin to release these eggs one at a time about once a month. This will continue to happen until a woman reaches menopause, which for most women occurs when they are in their fifties (although for some women it may happen sooner). During menopause, the egg-releasing mechanism gradually shuts down; little by little, the woman's periods become less frequent, until gradually she stops having them. Eventually, her body stops releasing eggs altogether. When this happens, she can no longer become pregnant, even if she still has intercourse, because there are no more eggs to be fertilized by the sperm.

B. **Teaching Anatomy and Physiology to a Lower-Functioning Group**

Audiences with less background may find anatomically correct dolls or models helpful--to talk about the differences between men and women and why there are differences. A doll and chart may be used together to show where the fetus develops and how it is born. One particularly helpful teaching aid is a full-body chart equipped with removable clothing. In addition to teaching basic concepts such as anatomy, it can be used to help facilitate discussions on such issues as private parts of the body. Full-body charts can be ordered from specialty suppliers, or you can make your own. Instructions for a home-made full-body chart are given below.

Full Body Chart

Materials Needed: Two squares of cloth for background, measuring approximately two feet by three feet each (dimensions can be adapted to your needs)

Materials Needed: (Continued)

An assortment of various colors of felt squares for organs, clothing, etc.

Yarn, buttons, glitter, etc. to "dress" your models

Needle and thread

Velcro strips or squares

Scissors

Glue

Markers

1. The first order of business is to design a full body for each square of background cloth; eventually, one will be male and the other female. The body can either be drawn on the cloth itself with markers or cut out of felt and glued or sewn to the background cloth. If felt is used for the body, it may be a little easier to attach your Velcro strips. It is important that your model is large enough to be seen at a distance--it should be almost as large as your background cloth--and it must represent a person with arms, legs, head and trunk so that your audience can visualize where the reproductive organs are.

2. For the female model: Using a different color of felt from the body, cut out two round circles to represent breasts. Nipples can be drawn on, or buttons sewn on (Two round band-aids do the job rather nicely and come with their own glue!). Sew or glue the breasts to the body. If you would rather, breasts can simply be drawn on. Using different colors of felt, cut out the following: uterus, fallopian tubes, ovaries, vagina. It is not necessary to have an exact representation--the uterus can simply be represented by an upside-down triangle, the vagina by a narrow rectangle leading down from the uterus, the ovaries by two small circles and the fallopian tubes by curved lines leading from the uterus to the ovaries. Glue or sew them in their appropriate places on the model.

3. For the male model: Using different colors of felt for each, cut out the following: penis, testicles, vas deferens, urethra (the prostate gland and seminal vesicles may be included if your model is large enough). Glue or sew them in their appropriate places on the model.

   NOTE: You may want to be able to remove internal organs to show which organs are visible on the outside and which are not. In that case, attach internal organs with velcro rather than gluing or sewing them on permanently.

4. Clothing for the female model: Cut a separate blouse and skirt that will adequately cover your female model. Attach velcro fasteners to the back of the blouse and to the torso so that the blouse will stay on when attached and can be easily removed. Do the same with the skirt. If you have used felt for the body, it may only be necessary to attach velcro to the back of the blouse and skirt and not to the body itself, as the velcro will adhere to the felt.

5. Clothe the male model in a shirt and a pair of pants. Attach as above.

6. Decorate your models as you see fit--yarn hair, button eyes, hats, shoes, socks, decorations on clothing, etc.

7. You can fold the charts for carrying, or you may prefer to staple them to wooden dowels and attach a string for hanging.

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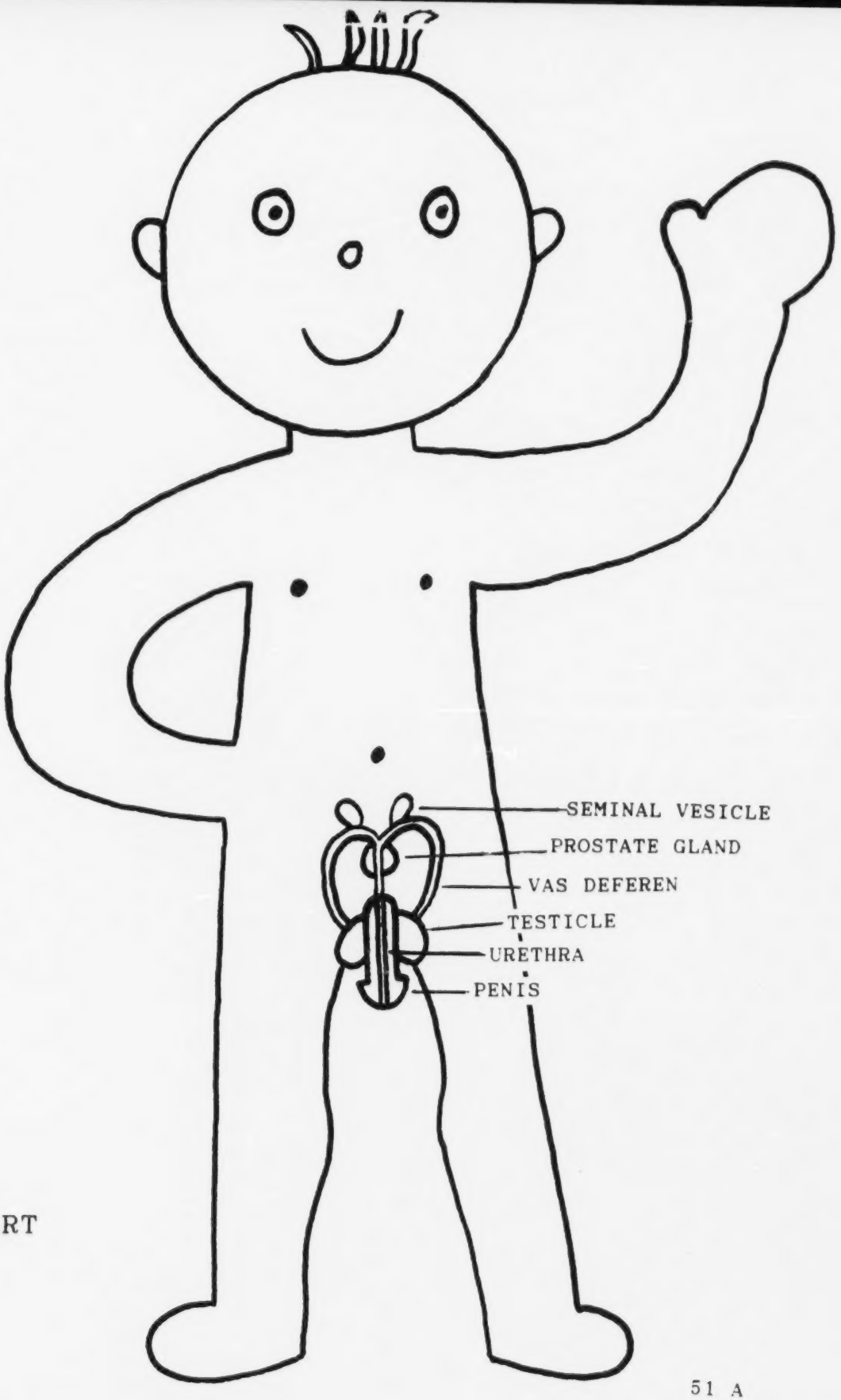
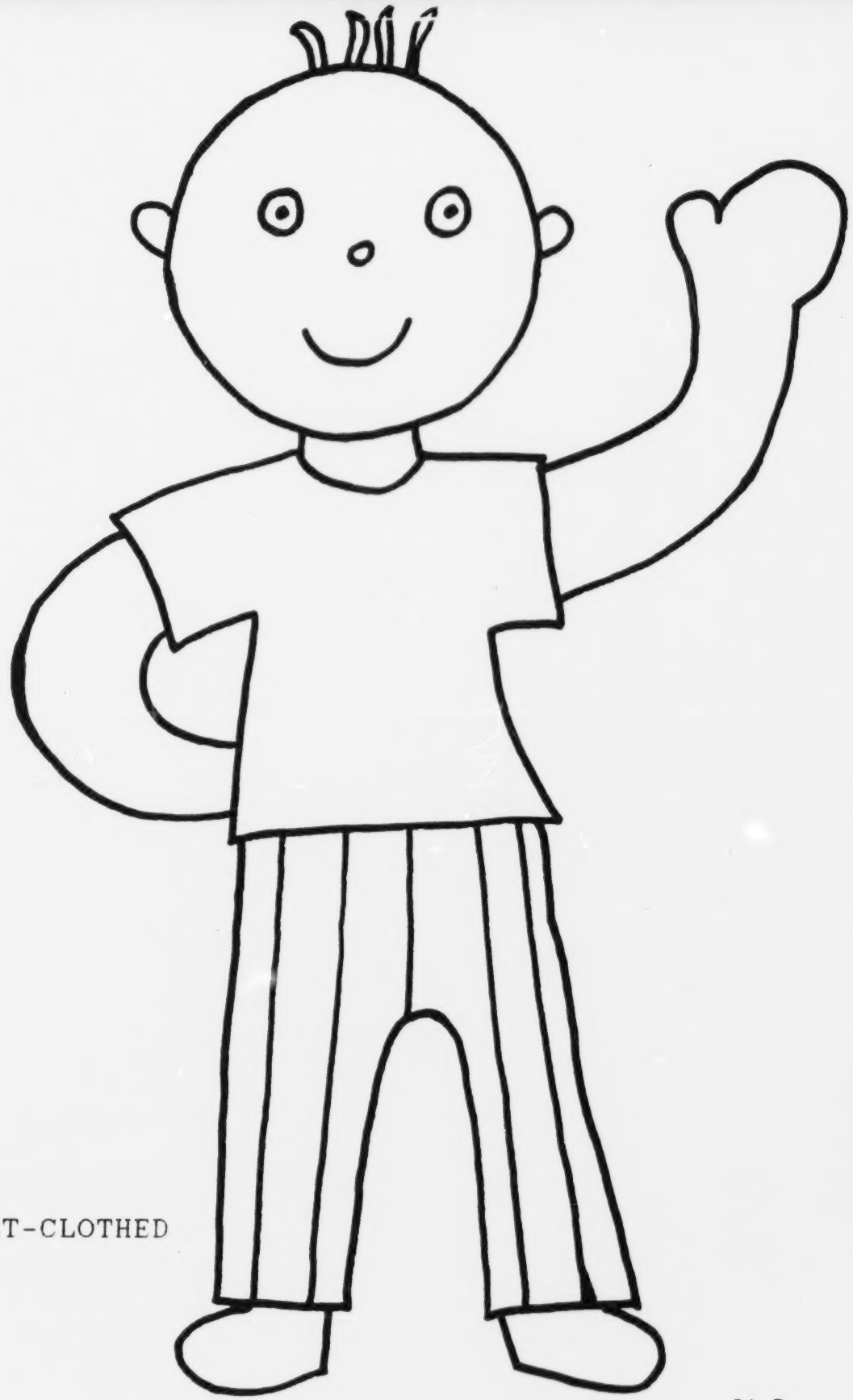


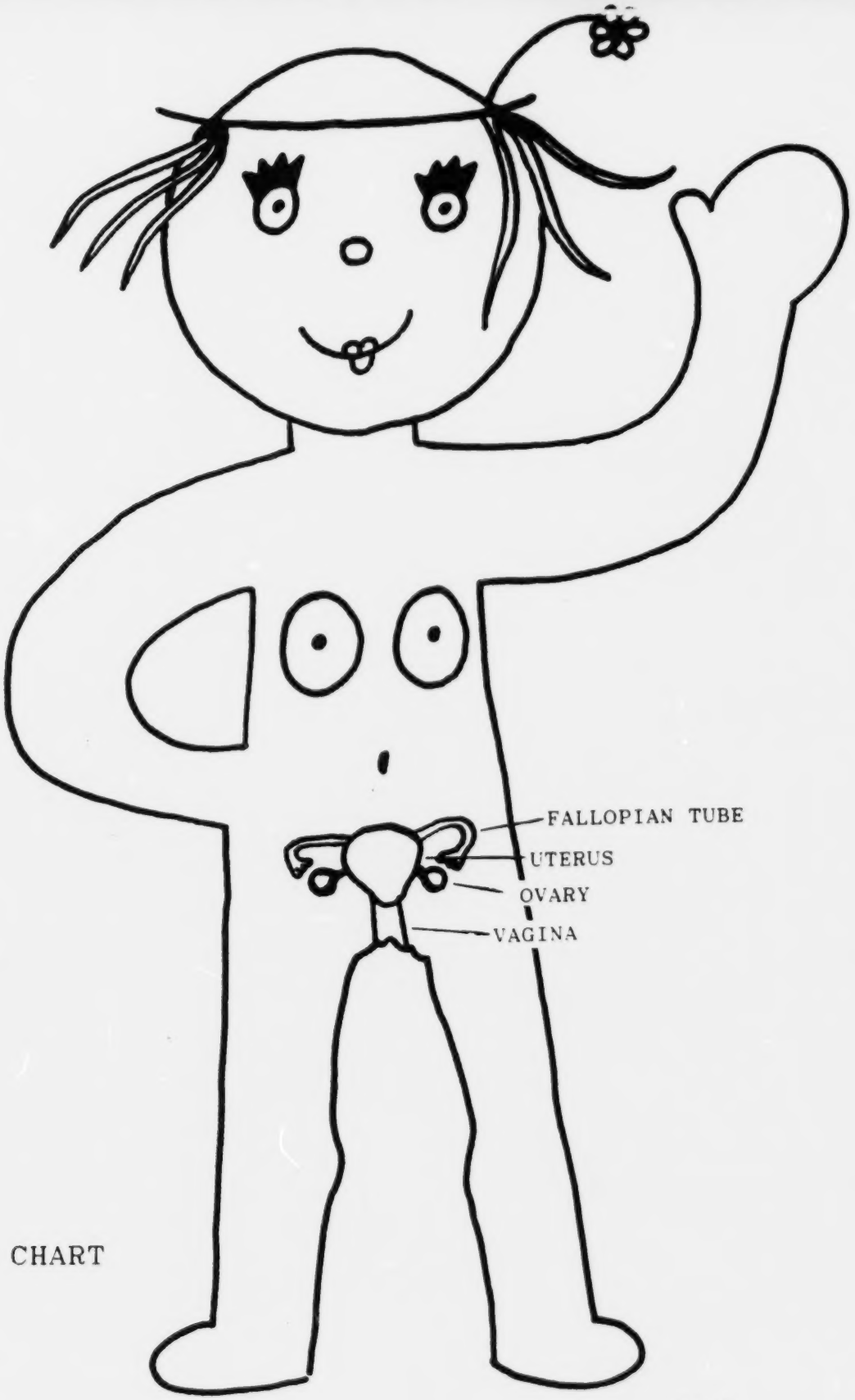
MALE CHART

51 A



MALE CHART-CLOTHED

51 B



FEMALE CHART

51 C

FEMALE CHART-CLOTHED

51 D

Magazine pictures can start a discussion about how men and women are alike and different from each other and how we can tell who are men and who are women. Pictures are also useful in talking about differences in characteristics among men and among women.

Materials Needed: Assorted magazines
Scissors
Glue
Construction paper

Instructors can prepare a collection of magazine cut-outs ahead of time, or elect to have the group itself work on the activity of locating pictures of men and women and grouping them into collages.

Sample Discussion Questions

- What are some ways men and women are alike? What body parts do both men and women have? What are some ways in which men and women differ? What body parts belong to each sex exclusively? How do we decide which pictures are of men and which are of women?

- What are some ways boys and men are alike? What are some ways in which boys and men are different? Why? Girls and women?

- How much variation is there among men's bodies? Among women's? What are some other clues that might tell us a person is male or female (clothing, length of hair, facial hair, etc.)? Are these clues always accurate? Why?

Audiences that are lower functioning may be able to introduce themselves and identify their gender, and perhaps recognize the gender of others. Questions such as "who are the men in the room? Who are the women?" can lead to a discussion about each sex's unique physical characteristics.

Sample Discussion Questions

- Do girls always grow up into women? Do boys always grow up into men? Where do babies grow?

- If a man grows his hair long, can he become a woman? If someone wished very hard, could he/she change into the opposite sex? Why not? What causes a person to be a man or a woman? Is it the clothes he/she wears? Is it a hairstyle? Is it a job he/she has? What if he/she changes his/her name--would that change the sex? If a man put on makeup would that change him into a woman?

- Which sex is able to give birth to babies? Can a baby begin growing inside its mother all by itself, just if a woman wants it to? How long does a baby grow inside its mother before it is ready to be born? Could a man have a baby if he wished very hard for one? Does a man have a special place for babies to grow inside his body?

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ACTIVITY SET #2: TEACHING ABOUT BIRTH CONTROL

If your birth control presentation is to be done in conjunction with a presentation of anatomy and physiology, you may introduce the birth control methods at various points during your presentation. If you are asked only to talk about birth control, your first priority is to ascertain your group's understanding of basic anatomy before demonstrating the methods you have brought with you.

A. Outfitting a Birth Control Kit

Teaching about birth control is one of the sexuality educator's most requested programs, and a good birth control kit is essential.

Materials Needed:
- Small case large enough to contain your materials (a shaving kit or cosmetics bag works nicely)
- Condoms
- Contraceptive foam and applicator
- Contraceptive jelly and applicator
- Contraceptive sponges
- Diaphragm
- Birth control pill pack(s)
- Paper towels

Additional materials, if you can find them, are a cervical cap, Norplant inserts and an IUD.

B. Teaching about Birth Control

Materials Needed: Birth Control Kit

Anatomical charts or diagrams of the male and female reproductive systems

Plastic model of the female pelvis for demonstrating application of foam or jelly and insertion of a sponge or diaphragm (optional)

1. Review anatomy, if necessary, stressing how pregnancy occurs.

2. Begin your discussion by bringing up methods that people often use that do not work (withdrawal, calendar method). Use your charts to illustrate.

Sample Questions and Answers

- How can a woman get pregnant if her male partner withdraws before ejaculating?

  A small gland in the male reproductive system, called the Cowper's gland, secretes a small amount of fluid before the man ejaculates. The purpose of this fluid is to clean out any old sperm or urine from the urethra before ejaculation. The man cannot control the fluid that comes from the Cowper's gland; it is released without his having to do anything and appears on the tip of the penis before he ejaculates. It may contain live sperm cells from the last time he ejaculated. If this fluid containing sperm comes in contact with his partner's vagina at any time, the sperm in the fluid can be passed on to her. For this reason, withdrawal is effective only 75% of the time; this means that the couple practicing withdrawal has a one in four chance of getting pregnant every time they have intercourse.

- Since a woman's egg only has 48 hours during which it can be fertilized before it dissolves, can a couple avoid pregnancy just by not having sex during those two days after she has ovulated?

  First of all, it is very difficult to predict when a woman will ovulate. The menstrual cycle, even in women who are very regular, can be easily upset. Every woman has had the experience of having her period delayed or brought on early by such things as taking a trip, the excitement of a holiday or by anything happening which may make her feel nervous or happy. Aside from the difficulty of knowing exactly when a woman is ovulating, it is not enough to know that the egg only stays around for a couple of days. Another problem is that male sperm cells can live for up to eight days waiting for an egg to show up in the woman's fallopian tubes! Even if a couple has sex during a woman's period, there is no guarantee that pregnancy will not occur. If his sperm lives for eight days and she ovulates, on the average about ten to fourteen days after the first day of her period, it is possible for one of his sperm cells to still be around when she ovulates. There is no "safe time" when it is OK to have sex without using birth control.

3. Demonstrate condoms. Refer to the "Facts About Sexuality" fact sheet on pregnancy and birth control for information about the condom. Stress its reliability and the fact that it must be used every time people have sex (even if they are using another method of birth control) because of its role in preventing disease. Show your group how to put it on properly by unrolling one over your hand, a banana, or other similar object. You might want to allow your group to do the same by passing out condoms and getting them to unroll them onto their own hands. (Check with your contact first about permission to do this.) Demonstrate its strength by sliding your other hand up inside the condom over your hand and stretching both hands apart. Talk about not putting anything on the condom that will hurt it (oil-based products,

exposure to heat). Talk about the proper way to withdraw the penis (hand around the base of the condom as the man withdraws to prevent spilling semen). Stress that a new condom has to be used every time--condoms are not reusable. Encourage the group to ask questions.

4. Demonstrate foam/jelly--filling the applicator, placing a dab of jelly in the tip of the condom to help with disease and pregnancy prevention, applying inside the vagina no earlier than 15 minutes prior to intercourse. Demonstrate how the applicator goes into the vagina using your pelvic model or your charts. (If using the model, do not actually apply foam or jelly to the inside of the model! It is messy and will make your demonstration of the sponge and diaphragm more difficult). Stress that foam and jelly should be used with a condom to make them more effective. If you like, you can squirt the foam or jelly onto a paper towel and pass it to the group.

5. Demonstrate the vaginal sponge. Explain that it must be moistened to activate the spermicide. Show how to fold and insert it, using the pelvic model if you have one; otherwise, place it next to your chart of the female reproductive system to show where it goes. Emphasize that the vagina and the urethra are separate passageways in women's bodies--a woman may go to the bathroom with the sponge or diaphragm in place. Also, point out that the sponge cannot get lost in the body. It is held in place in the vagina and cannot go anywhere else.

6. Demonstrate the diaphragm as you did the sponge, using your model or chart. Explain how it must be used with contraceptive jelly or cream, but do not actually fill the diaphragm. Pass the diaphragm to the group to allow them to examine it or practice inserting it in the model.

7. Explain how the birth control pill works. Explain that each pill in the 21-day group contains a message to a woman's ovaries saying, "Do not release an egg today." Because the pill only contains a message that is good for 24 hours, another pill has to be taken the next day at the same time so that the ovaries get the message again. Ask for questions. Many groups have a lot of questions about the pill, as it is one of the most widely used methods. Most questions have to do with side effects and efficiency. Let the audience look at the pill packs.

If you have a cervical cap, Norplant inserts or copies of inserts, or an IUD, explain them to your group. And as you demonstrate each method, you should continue to stress that condoms must be used along with each method to prevent disease.

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ACTIVITY SET #3: TEACHING ABOUT PREGNANCY AND PARENTING

Individuals who actively participate in their community will usually have questions or comments about this subject. Reviewing pregnancy, how it occurs, and appropriate prenatal care are important subject areas. Responsibilities of parenting, things babies will need (food, medical care, housing, clothes, diapers, love, etc.) and circumstances that might make parenting difficult should also be explored.

Sample Discussion Questions

Is everyone ready to be a parent? Should everyone parent? Why might a person choose not to become a parent? What steps would a person take to ensure that he/she would not become a parent before he/she is ready? What responsibilities do fathers have for their children?

Other audiences may have more specific, concrete concerns regarding pregnancy and parenthood.

Sample Discussion Questions

How does a person get pregnant? How can you tell if you are pregnant? Can kissing make you pregnant? Can you get pregnant only if you are married? Why do some people not have children?

You might need to review the basics for less sophisticated audiences.

Sample Discussion Questions

How does pregnancy happen? Can a woman get pregnant all by herself? What sex carries the developing fetus inside? What sex contributes sperm as a part of creating a baby? What sex contributes the egg? Is it like an egg from the supermarket? Where does the baby develop? How long does it take? How does it get born?

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ACTIVITY SET #4: TEACHING ABOUT RELATIONSHIPS

Higher-functioning audiences may want to share their own experiences with relationships in their lives. This can lead to a more general discussion of the different types of relationships and their roles in our lives.

Sample Discussion Questions

How are feelings appropriately expressed in different types of relationships? What are one's responsibilities in a relationship? What are some differences between friendship relationships and sexual relationships? Are there added responsibilities in a sexual relationship? Why?

The audience may role-play scenarios from relationships, gaining skills to use in social situations or strategies to utilize in uncomfortable or exploitative situations. Role-playing is a useful tool that provides a concrete situation for the audience to discuss and analyze. It may also serve as a reinforcing, non-threatening practice for real-life situations, providing practice in negotiation and assertion.

Guidelines for Role-Playing

1. Choose role-players carefully. Ask for volunteers, or try to select individuals who will not feel threatened by this activity. Never demand participation from any individual.

2. Role-play scenarios should be emotionally charged and open-ended. The facilitator should end the description of the scene at the point when the audience begins to wonder, "What happens next?"

3. The facilitator may give just enough detail to begin a spontaneous role-play, or may provide a prepared situation (especially if the group feels confused or unsure about an unstructured activity). In either case, be careful not to discourage creativity.

4. Allow a brief period of time for participants to think about their roles before beginning.

5. Stop the role-play at its peak. Allowing a role-play to go on past this point often results in its dragging out indefinitely, or disintegrating into uncontrollable giggles. The discussion that ensues from a situation stopped at mid-point is likely to be lively.

6. Encourage discussion. How did each participant feel about his/her role? The other characters? How did the audience react to the participants' behavior choices? Would the role-players rather have acted differently? How would the audience have acted in those roles? What caused the characters to make the choices that they did? Could any factors have been changed?

7. Assist the participants in disassociating themselves from the characters they played--call them by name or ask how they personally felt about their role.

8. You may also introduce variation in one of several ways. Have an entirely new group of participants act out the same scenario to illustrate alternate ways to deal with the same situation. Have the role-players switch roles midway through the action to illustrate how it feels to be on the other side of one's

actions. Have another person stand beside each role-player to voice the character's thoughts, to explore the values and feelings that are a part of decision making.

Sample Role Play Scenarios

1. You are in the lunchroom at work and see a co-worker at the next table whom you would like to get to know better. What do you do?

2. You and your partner have been dating for several months. You are interested in having intercourse; your partner does not feel ready. What does each character do?

3. You feel that your mother still treats you like a child. You do not like this, but also do not want to hurt her feelings. How does each character respond?

4. A stranger on the bus tries to touch you in a private place. What do you do?

5. You have lost your way in the city. You know your telephone number and address. It is getting dark. There are several strangers, a bus stop, and a man in uniform nearby. What happens next?

6. You and your roommate are having problems deciding how the chores should be split up. Neither of you thinks that the other person's solution is fair. Except for this one disagreement, you both get along fine as roommates. What do you decide? What if in addition to this disagreement over the chores you also disagree on just about everything else too, and do not seem very suited as roommates?

7. You want to ask the person that you are interested in to the dance this weekend. You are rather shy. The other person is not so shy, but does not know of your interest. What happens next?

8. You and a friend are walking downtown. A group of teenagers begin calling you derogatory names. What do you do?

9. You have been standing at the counter in a store for quite a long time, waiting for assistance from the clerk. She seems to be ignoring you. You think about just giving up and going home, but this is your only chance to purchase a birthday gift for your sweetheart. You also do not want to anger the clerk. You need her help, but you think she may be avoiding you because you are retarded. What happens?

10. A stranger in a store asks you to "help" him by putting some merchandise into your backpack that has not been paid for. What happens?

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Favorite TV or movie characters may be discussed in terms of their relationships and the possible consequences and outcomes of their behavior.

Suggested list of TV shows:

Daytime soap operas
Dallas/Falcon Crest/Dynasty
The Love Boat
Laverne & Shirley
My Three Sons
Bonanza
Little House on the Prairie
The Waltons
The Cosby Show
Fantasy Island
The Jeffersons
The Brady Bunch

These and many other television programs can serve as a springboard to discussions regarding relationships, conflict resolution, decision making, and even specifics of sexuality.

Suggestions for Lead-In Questions

- What did you think of how that character acted? Would you have liked it to turn out differently? Why?

- Would that really happen in real life? Why or why not?

- Did that couple talk about protection before they began their sexual relationship? What do you think about that?

- If you were a character on that show, who would you most like to be? Who would you least like to be? Why?

- Could that show have turned out any differently, even if the characters acted the same way?

- What other choices could that character have made and how might that affect what happened next?

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Pictures from magazines can serve to illustrate different types of relationships, which the audience can identify and describe.

Materials Needed: Assorted magazines
Scissors
Glue
Construction paper

You can prepare the picutres before the workshop (mount them on construction paper) or allow the group to cut them out. Advertisements, especially perfume, clothing and film ads, frequently portray diverse types of relationships. Try to include the following examples of relationships: family, friends, co-workers, doctor/patient, business, lovers, rivals, teacher/student, etc.

Sample Discussion Questions

- What relationship do the people in this picture have? How can you tell?

- What do you think about the way this character is shown in this picture? Would this happen in real life?

- Which kinds of relationships do we have a choice about entering into? Which ones do we not have a lot of choice about? What can we do about this?

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ACTIVITY SET #5: TEACHING ABOUT SEXUALLY TRANSMITTED DISEASES

It may be helpful to quickly review the basics of anatomy and physiology with your audience, to re-familiarize them with the information and provide a background to the topic.

Some audiences may already have limited knowledge about sexually transmitted disease, and a question and answer session may meet their needs. Helpful materials to have on hand may include anatomical charts of the male and female reproductive systems, brochures about STDs, and photos depicting the appearances of some STDs, if available.

Sample Questions and Answers

- Who can get sexually transmitted diseases?

  Anyone, male or female, can get a sexually transmitted disease from any sexual partner already infected with a STD. Even if that partner does not know they are infected, they can still pass the infection on to others.

- Will a sexually transmitted disease go away on its own?

  No! Only a doctor can cure STDs. Anyone who is worried that he or she may be infected should visit a provider or clinic right away, and then follow all the instructions that are given to be sure the disease is cured.

- Once a person gets a sexually transmitted disease, can he or she get that same disease again?

Yes. A person could be infected over and over with the same STD (or with others). Being cured once does not make you immune to STD.

- What if a person does not have an STD treated?

A person with untreated STD can pass it on to any of his/her sexual contacts. An untreated STD can cause many problems like pain, infertility, or even death. Luckily, most STDs are very easy to cure if a person seeks treatment right away.

- What are some symptoms of STDs?

Any sore or blister near the genitals or mouth, any unusual discharge or change in appearance of the sex organs, or a painful feeling during urination might be signs of STD. The only way to know for sure is to visit the doctor. Some people are infected with STD and have no symptoms, so it is important for all sexually active people to be checked for STDs regularly, especially if they have more than one sex partner.

- How can I protect myself from STD?

People who do not have sex cannot get STDs so folks who abstain from sex are sure that they are safe from STDs. People who are sexually active can take measures to protect themselves. Knowing your partner is important. If you notice any unusual bump, rash, or other symptoms, do not have sex with them. Condoms are a method of birth control that also give some protection against STDs because they act as a barrier to STD germs.

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Some audiences may need a broader background regarding disease and transmission of disease. A discussion of germs and illness is important.

Sample Questions and Answers

- How do people get sexually transmitted diseases?

  Some germs cause people to get a cold or the flu, while others cause STDs. The germs that can cause STDs are passed from one person to another during sex.

- Could someone catch an STD from a doorknob? A handshake? A sneeze?

  No. We can catch some germs in those ways, but not STD germs. STD germs like to live in warm, moist places like inside people's bodies. They can only go from one person to another during close physical contact. You could get a cold from a sneeze or a handshake, but you could not get an STD that way.

- If a person thinks he or she has an STD, what should be done?

  Only a doctor can decide if a person definitely has an STD and only a doctor can cure an STD. So, a person who is worried should make an appointment with the doctor or ask someone to help him or her make an appointment.

- How does a doctor cure STDs?

Almost all STDs can be easily cured. A doctor has to figure out what kind of STD the patient has, then choose the right kind of medicine to make it go away. The patient has a very important job too--the patient has to take all the medicine the doctor prescribes and follow any other instructions the doctor has given, as exactly as possible.

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You may need to review very basic health information with other audiences. Stressing the definitions of feeling well versus feeling sick and the procedures for taking care of health needs, should be the central focuses.

Sample Questions

- What is the difference between being well and being ill? What causes people to become ill? Are there things we can do to prevent illnesses?

- Whom do you tell if you are ill? What happens next?

- What are some symptoms of different types of illnesses?

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APPENDIX

FACTS ABOUT SEXUALITY:
PREGNANCY AND BIRTH CONTROL

WHAT ARE THE FACTS OF INTERCOURSE WITHOUT CONTRACEPTION?

The fact is, people who have sexual intercourse without using contraception (birth control) run a very high risk of becoming parents. For people desiring to start a family, that is great news! For people who are not yet ready to become parents, the odds are against them. There is only one way to ensure that pregnancy will not occur, and this is abstinence--refraining from vaginal intercourse.

There is a wealth of folklore many people have heard regarding ways to prevent a pregnancy. Have you ever heard of any of these statements?

- You cannot get pregnant the first time you have intercourse.
- You cannot get pregnant if you do it standing up.
- Urinating after intercourse will prevent conception.
- Douching after intercourse will prevent conception.
- Withdrawal is an effective method of birth control.
- You cannot get pregnant if the penis does not fully enter the vagina.
- You cannot get pregnant during your period.
- Birth control is difficult and expensive.
- There are "safe" times to have intercourse without birth control.

ALL OF THOSE STATEMENTS ARE FALSE!!

Although many people have heard most of these statements, none of them are true. If you don't want to be parents, it is important not to engage in intercourse or have the penis and vagina near each other before, during, and after ejaculation so the egg and sperm cannot meet.

WHAT ABOUT BIRTH CONTROL?

There are some very effective methods of birth control available in this country. A couple who uses birth control correctly and consistently can be 99% protected from an unplanned, unexpected pregnancy.

Some methods may be purchased in a drugstore. Condoms, contraceptive sponges, and contraceptive foams, jellies, and creams are available in drugstores, some supermarkets and convenience stores, and sometimes even in vending machines! All come with instructions for proper use, and all must be used correctly to be most effective.

Other methods of birth control can only be obtained from a physician. Diaphragms, IUDs, and birth control pills can be obtained only by visiting a health-care provider. The provider can supply information about these methods and help each person or couple select the method that is right for them.

Some people choose sterilization (vasectomy or tubal ligation), a permanent birth-control method. This is a decision that a person might make after consulting with a physician.

THE METHODS

Condoms: 90% effective. This means that if 100 couples have sex for a period of one year, at the end of that year, 90 of the couples will not be pregnant but ten of them will. Condoms can be damaged by using oil-based lubricants such as vaseline or baby oil. If extra lubrication is desired, a water-based lubricant such as K-Y Jelly or contraceptive creams or jellies made to be used with a diaphragm should be used. Condoms should be stored away from heat--a condom that has been carried in a wallet for a long time should not be used, because a person's body heat can damage the latex. They should be used before the indicated expiration date. After ejaculation, care should be taken to remove the condom promptly away from his partner's body before the man loses his erection. Condoms are easily obtainable at drug stores, clinics and even from vending machines. Condoms should be used all

the time, even if another birth control method is being used, because they are the only method that prevents transmission of disease and protects against pregnancy.

Contraceptive foams and jellies: Should be used along with a condom. They can increase the efficiency of a condom to 99%, which is as good as the birth control pill. They should not be used alone, as their efficiency rate without a condom is only 45%. They are to be used by a female partner who inserts the foam or jelly in the vagina (using an applicator) no more than 15 minutes prior to intercourse. A dab of jelly or cream may be placed in the tip of the condom before it is put on (products containing the spermicide nonoxynol-9 have been shown to be effective in killing the virus that causes AIDS). Spermicides work by killing any sperm they come in contact with; they are an extra measure of protection in case of leakage from the condom.

Vaginal sponges: 84% effective, although the efficiency can be increased by using a condom along with the sponge. The sponge contains a spermicide that is activated when water is applied, causing the sponge to foam up when squeezed. It can be inserted in the vagina up to 24 hours prior to intercourse and must be left in place for at least six hours after the last intercourse. Intercourse may be repeated as many times as desired during the 24 hours that the sponge stays in place. Some people find the sponge difficult to insert and it can become dislodged during intercourse. It works by placing a barrier over the cervix and the spermicide it contains works to kill any sperm it comes in contact with.

Diaphragms: About 96% effective. Must be used along with spermicidal jelly or cream, about a tablespoon of which is placed and smeared around the inside and along the rim. Must be obtained from a doctor because women are different sizes and the diaphragm must be fitted. The diaphragm must be inserted no sooner than six hours prior to intercourse; if intercourse is repeated, the woman needs to apply more cream or jelly using an applicator. The diaphragm must be left in place at least six hours after intercourse.

Birth Control Pills: 99% effective. Must be obtained from a doctor. The pill works by sending a message to the woman's ovaries telling them not to release an egg for the next 24 hours. This message is repeated in each pill each day for 21 days; at the end of that period, a pill is taken that does not contain the message and the woman has her period. She then starts a new pill pack. Possible side effects include spotting between periods, depression, weight gain, nausea, etc. and may mean that a woman needs to get a different type of pill, not that she cannot take the pill. Women who should not take the pill are those with high blood pressure or heart problems, or women over 35 who smoke. Most others should be able to take the pill without experiencing side effects.

IUDs: 98% effective. We are not really sure how the IUD works, although there is some reason to believe that it prevents implantation of a fertilized egg. It must be inserted in the uterus by a doctor while the woman is having her period. It may cause heavier periods. It can be left in place up to three years, depending on the type inserted.

Norplant: More than 99% effective. It is a new method that was just approved for use in this country in November 1990, although it has been used for many years in Europe and Africa. It consists of six small tubes, roughly the size of matchsticks, which are inserted under the skin on the underside of one arm. Hormones are slowly released that suppress ovulation for as long as five years. It becomes effective within 24 hours of insertion and when removed, allows fertility to be restored within 24 hours. Known side effects include break-through bleeding between periods, which in some women is severe enough to cause them to have the implants removed. There is some evidence that break-through bleeding subsides within nine months after insertion. Indications are that the inserts are less effective in women who weigh over 150 pounds. The major drawback to the method is the cost, which runs from a minimum of $500 to as much as $1,000, depending on the physician.

HOW CAN I LEARN MORE ABOUT BIRTH CONTROL?

The library, any local health information telephone number, or a Planned Parenthood clinic can provide information about birth-control methods. A clinic or private physician would be able to help choose the appropriate birth control method for one's lifestyle, and could supply information about a variety of important reproductive health issues.

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FACTS ABOUT SEXUALITY:

SEXUALLY TRANSMITTED DISEASES

WHAT ARE SEXUALLY TRANSMITTED DISEASES (STDs)

STDs are diseases that infect the sexual and reproductive organs. You may have heard them called VD or venereal diseases. STDs are caused by a variety of bacteria and viruses and can be painful and serious, even possibly causing damage to the reproductive system if not treated promptly.

Most STDs can be cured with prompt treatment. Some people can have an STD without knowing it because they have no symptoms, or because their symptoms have gone away without treatment. Even in these cases, they still have the STD until they are treated.

HOW ARE STDs SPREAD?

STDs can live in warm, moist areas, so they usually infect the mouth, rectum, and sexual organs. They can be spread during vaginal, oral or anal intercourse. They are NOT spread through touching doorknobs or other objects, using public restrooms or infrequent bathing.

WHO HAS STD?

STDs are very common. If a person is sexually active in anything other than a mutually monogamous relationship, the chances of contracting an STD are high.

WHAT ARE THE SYMPTOMS OF STD?

Any of these symptoms may mean STD infection: sores or blisters near the sex organs or mouth, any swelling around the sex organs, a painful or burning feeling when urinating, or any unusual discharge from vagina or penis. Any of these symptoms should be checked promptly by a physician.

SOME COMMON STDs

Chlamydia: caused by a bacterium that can be transmitted during sex. Symptoms usually appear in one to three weeks, but many men and women may show no noticeable symptoms when infected. Bleeding or discharge from the vagina, pain during urination, or abdominal pain with or without fever may be symptoms of infection in women. For men, a discharge from the penis or painful urination may be signs of infection. Untreated chlamydia can lead to serious infection, which may cause reproductive damage or sterility in either sex. It can also be passed from mother to baby during childbirth. Doctors test for chlamydia by using a smear, and it is treated with antibiotics like tetracycline.

Gonorrhea: also caused by a bacterium, transmitted during sex. It can also infect the eyes if touched by fingers with infected discharge. Symptoms usually appear a few days to three weeks after infection. Some women and men experience no symptoms, even though they are infected and can pass the infection on to other partners. Abnormal discharge or painful urination are signs of infection in both sexes and abdominal pain may be a symptom in women. Untreated gonorrhea can lead to other health problems, including pelvic inflammatory disease, heart trouble and arthritis. It can be passed from mother to baby during childbirth. A gram stain or culture is used to detect infection, and antibiotics are prescribed as treatment.

Genital Warts: caused by the human papillomavirus (HPV). Symptoms may appear one to six months after infection. Small, painless bumps appear on or near the sex organs and/or inside the female reproductive system where they may not be noticed. They can also appear around the anal area where they may be mistakenly identified as hemorrhoids. Women with genital warts on the cervix appear to have a higher rate of cervical cancer than uninfected women. Pregnant women infected may experience enlarging of warts during pregnancy as a result of increased hormone levels and lesions on the vaginal wall may make childbirth difficult because the vagina loses elasticity due to the lesions. Practitioners diagnose genital warts by visual

examination, or, rarely, by biopsy. Treatment consists of removing the lesions in one of several ways. They may be burned off using special solutions or creams, frozen using liquid nitrogen or dry ice, removed surgically or through electric current to destroy the lesion, or removed using laser surgery.

Syphilis: caused by a bacterium. The disease goes through several stages, beginning with a painless sore (a chancre) that may appear from one week to three months after infection. The sore is usually near the genitals but may be at any other point where the bacteria entered. Some people may not notice the chancre, especially if it occurs inside the female reproductive system. Whether noticed and treated or not, the chancre will disappear several weeks after it appears. The disease continues to progress, however, unless it is treated. The next stage, which begins any time from a week to six months later, may last several weeks or months, or may recur over the course of several years. Flu-like symptoms and rash appear. If still untreated, the bacteria continue to multiply within the person's body. There is a later stage, lasting upwards of ten years, during which time the person may experience no symptoms, yet the bacteria now attack the vital organs of the body. The last stage begins when this damage begins to surface. Blindness, joint degeneration, damage to the heart and brain as well as death can result. A blood test reveals syphilis infection. Treatment is by antibiotic. The disease can be detected throughout the stages and the bacteria stopped; yet if organ damage has occurred, the internal damage may never be repaired. Pregnant women can pass infection on to the fetus, resulting in disease, disability or death.

Herpes: caused by the herpes simplex virus. The virus can enter the body through mucous membranes. Symptoms may include flu-like feelings and small, fluid-filled uncomfortable sores near the genitals or mouth. Sores may also appear on the cervix. The sores eventually heal without treatment, but may recur, usually in milder form. About three-quarters of all people infected with herpes have recurrences of the sores. There is no cure for herpes; a person who contracts herpes will have it for

the rest of his/her life. Contact with the material inside the sores transmits infection; it cannot be passed on if a person is not experiencing an outbreak. Herpes can be transmitted from mother to baby during birth and also has been implicated as a cause of miscarriage and premature birth. There are now new treatments that can help prevent recurrences and cause recurrences to be less severe.

HOW CAN I AVOID STDs

If you have more than one mutually monogamous sexual partner, you can take measures to protect yourself from STD'. Know your partner and be aware if he/she shows any signs or symptoms of STDs. If so, do not have intercourse.

Using a condom and birth control foam, jelly or cream will protect against STDs much of the time. Have regular checks for STDs every six months if you have more than one partner.

WHAT IF I HAVE AN STD?

Follow your physician's instructions. Take all the medicine prescribed, even if you begin to feel better. Inform your sex partner(s) so they can be treated too. Do not have intercourse until the STD is gone. The only way to know that you are cured is to be tested for the STD again, usually several days after you finish your medicine. Remember, STDs can be very serious if not treated promptly.

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FACTS ABOUT SEXUALITY:

AIDS

WHAT IS AIDS?

AIDS (Acquired Immune Deficiency Syndrome) is a breakdown of a person's immune system, caused by the Human Immunodeficiency Virus (HIV). Once the immune system begins to break down, the individual can no longer fight off all of the bacteria and viruses that are constantly around us. Therefore, a person with AIDS could die from the simple cold germs most people easily fight off, or they succumb to strange, rare diseases that usually have no chance to get a foothold in a body with healthy immune responses.

Some people contract these infections and die soon after being diagnosed with AIDS, while others may be infected with HIV for 10 years or more without any symptoms at all. There is no cure for AIDS but there are treatments for some of the infections that people with HIV infection are prone to contracting. Once a person is infected, there is no treatment that will kill the virus and the infected person can transmit the virus to others, even if (s)he has no symptoms.

WHO HAS AIDS?

Men, women and children of every class, race and sexual orientation have AIDS. The virus does not discriminate--if it can enter the bloodstream it does not matter if the body it enters is heterosexual, homosexual or bisexual. HIV is able to infect people because of their behaviors--what they do; not who they are. Millions of people worldwide are infected with HIV.

HOW DOES ONE BECOME INFECTED?

The most important thing to remember is that AIDS is difficult to get. People can become infected in only a few ways:

- Sexual intercourse
- Sharing needles or works, ear-piercing or tattooing equipment
- From infected mother to fetus
- Receiving infected blood or blood products (prior to 1985 when routine blood testing was introduced)

through these routes:

- infected blood
- infected semen
- infected vaginal fluid

This means that during most of the things we do, we need not fear becoming infected with HIV. HIV is not a very strong virus--people cannot become infected by hugging or kissing, sharing food, donating blood, using public restrooms or water fountains, or even being sneezed on by someone. It also is not transmitted by dogs, cats or insects. HIV can only be transmitted if an infected body fluid listed above enters another person's bloodstream.

HOW CAN WE PROTECT OURSELVES?

Prevention is the best defense against the virus. Abstinence combined with not sharing needles or works is the 100% sure way to avoid coming into contact with the virus. People who, since 1978, have been and continue to be in a mutually monogamous relationship, who have not shared needles with others and who have not received blood before 1985 have little chance of infection.

People who share needles can reduce the risk of transmission by learning to clean works (using bleach). Once again, prevention is the best defense--people who avoid sharing needles or works with others (whether injecting drugs, piercing body parts or making tattoos) are practicing the safest behavior.

If you are sexually active--know your partners! You are not only being intimate with them, you also share the legacy of their past sexual contacts, and those sexual partners' sexual contacts, etc. Condoms, used properly, offer protection against the virus because they act as a barrier against it. Dental dams (found in dental supply catalogues or at some community health organizations) are also effective as barriers when used during oral sex with a female partner. Condoms will also protect sexual partners from other sexually transmitted diseases. This is important because someone infected with an STD can transmit HIV twenty times more effectively to a partner than a person not infected with any other STD.

WHAT ABOUT PEOPLE WITH HIV INFECTION?

They need our support and caring. There are many people who have now been living with HIV infection for years. They deal with many types of discrimination that most of us might will never encounter. Some have lost health insurance, jobs, friends and families as a result of others' reactions to the virus or as a result of the disastrous financial effects of living with a potentially devastating, terminal illness. Offering to do errands, helping with housekeeping or children, or just visiting can be some of the most appreciated gifts one can provide an HIV-infected person.

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FACTS ABOUT SEXUALITY:
HOMOSEXUALITY

WHAT IS HOMOSEXUALITY?

Homosexuality is the term used to describe a person whose main physical and emotional attachments and attractions are to others of the same sex. A heterosexual person is one who is primarily attracted to those of the opposite sex.

WHO IS HOMOSEXUAL?

About 10% of the population are homosexual. Gay men and lesbian women live in all parts of the world and are members of all races, religions and social classes. They are engineers, construction workers, secretaries, attorneys, homemakers, mothers, fathers, children, aunts, uncles and cousins. They lead lives as diverse as those of heterosexuals. They work, shop, go to the library, establish long-term relationships, pay bills, watch TV and pay taxes. Everyone knows homosexual people, even though he/she may not realize it (your mailman, or the clerk at the convenience store, or a neighbor, or someone in your family). Some homosexual people may fit certain stereotypes that we have about gay people. Most, however, do not look or act any differently from the heterosexual population. Physical mannerisms and appearance have nothing to do with a person's sexual orientation. And, just as heterosexuals are selective about their intimate partners, homosexuals are not attracted to all members of the same sex, but to individuals.

IS HOMOSEXUALITY HARMFUL?

Homosexuality is not a disease or a mental illness. Gay men and lesbian women are not sick or confused. They have neither more nor less interest in sexual activity than heterosexuals.

Homosexuals are not the twisted child molesters that many assume. In this country, 90% of all childhood sexual abuse is committed by heterosexual men on female children.

WHY ARE SOME PEOPLE HOMOSEXUAL?

Although there are several theories, no one knows for sure why some people are heterosexual and others are homosexual. Some people are aware of their sexual orientation at an early age. Others become sure of it later in life.

Having one homosexual experience or having a few does not "make" a person gay or lesbian. The majority of young people do experience at least one homosexual event in the course of exploring their sexuality, and this is completely normal. In addition, having had a homosexual experience as a result of sexual assault or incest cannot "make" a person homosexual.

Most gay men and lesbians grow up with typical, heterosexual parents and families, as do most heterosexual people. Interestingly enough, the children of gay parents are statistically more likely to be heterosexual than the children of heterosexual parents!

Contrary to stories many have heard, people cannot "catch" homosexuality like a disease or become "recruited" to be homosexual by others. The manner in which people come to recognize their affectational preference, whether homosexual or heterosexual, has nothing to do with being influenced or taught by others. Are heterosexuals "taught" to be straight?

It can be difficult as a gay man or lesbian in our society--many forms of overt and covert discrimination exist all around us. In light of this, why would someone choose to be homosexual?

WON'T ALL HOMOSEXUALS GET AIDS?

No. AIDS is not a disease of gay people. The virus that causes AIDS has nothing to do with what gender you and your sexual partner are. It is transmitted on the basis of what people do (their behavior), not who they are (their orientation).

In fact, lesbians have the lowest rates of sexually transmitted diseases of any group in this country.

WHAT IF I'M GAY?

Almost everyone questions his/her sexual identity at some point in his/her life. In fact, it is quite normal. There may be some--straight or gay--who have always been quite sure about their sexual identity. This, too, is normal. The most helpful thing may be to talk about sexual identity with a trusted individual. There are many local gay and lesbian hotlines that can provide support and information about resources in your area.

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FACTS ABOUT SEXUALITY:
MASTURBATION

WHAT IS MASTURBATION?

Masturbation is touching or stimulating your own sexual organs. Many people of all ages, men and women, masturbate. People masturbate because it gives them pleasure or relaxes them. Some people do not like to masturbate or find that it is against their beliefs. People who masturbate are normal; people who do not masturbate are normal.

IS MASTURBATION HARMFUL?

Many people have heard stories about the harmful effects of masturbation. There is no way that masturbation can hurt a person--it does not cause mental illness, hairy palms, blindness or any other ill effects. Some people masturbate frequently. Others may masturbate only when their partner is away or ill. Either way, it is not harmful.

WHY DO PEOPLE MASTURBATE?

Masturbation is one way to relieve sexual tension without worry about pregnancy, sexually transmitted diseases or AIDS. Some people find masturbation a useful tool in learning about their reproductive anatomy, or as a way to explore the body's responses in order to know what activities give pleasure so that they may communicate these to their partner. For others, masturbation may be the only outlet they have for expressing their sexuality, due to the unavailability of a suitable partner.

THE IMPORTANT FACTS ABOUT MASTURBATION

Once again, masturbation is a normal activity to choose to engage in, or not to engage in. Masturbation does not cause any mental or physical ills and does not cause a person to be sexually promiscuous or aggressive or homosexual or bisexual. It may be a temporary outlet for sexual feelings or the only realistic choice for sexual expression, depending upon a person's situation. It is important to note that in our culture masturbation is usually only considered appropriate when done in a private place (like a bedroom or bathroom with the door closed). It may become our responsibility to point this out to individuals in our care. We may feel that some individuals display inappropriate sexual behavior, only to realize that "private" places may be much more difficult to find for people who live in an institutional setting.

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GLOSSARY

Bartholin's Glands: Two small glands on either side of the vaginal opening.

Cervix: The entrance to the uterus.

Clitoris: Organ in female reproductive system solely for sexual arousal.

Cowper's Glands: Produce a fluid within the male reproductive system that neutralizes the acidity of the urethra before the sperm pass through.

Egg: Released from ovaries, the female contribution to the making of a baby.

Ejaculation: Release of semen from the penis.

Epididymis: Sperm travel through these tubes while maturing.

Erection: Stiffening of the penis due to its spongy tissue filling with blood in response to sexual or other feelings.

Fallopian tubes: Tubes that are the passage for eggs to travel toward the uterus from the ovaries.

Genitals: Sex organs of males and females.

Hymen: Fold of tissue that may partially cover the vaginal opening.

Labia: Folds of skin below the mons that are sensitive to stimulation and protect organs they surround.

Masturbation: Stimulating one's own sexual organs.

Menopause: Time in a woman's life when her ovaries stop releasing eggs; she no longer menstruates.

Menstruation: The periodic shedding of the lining of the uterus.

Mons: Mound of tissue with many nerve endings above the outer folds of skin of the vulva.

Nocturnal Emission: Release of semen during sleep, also called a wet dream.

Ovaries: Two organs that produce hormones that control female development and release eggs periodically as a part of the menstrual cycle.

Ovulation: The release of an egg by an ovary.

Penis: Male organ through which urine or sperm may leave the body.

Perineum: Area between labia and anus.

Pituitary Gland: Gland in the brain that produces hormones regulating growth and reproduction.

Prostate: Gland which produces a fluid that becomes part of semen.

Puberty: The time in a young person's life, usually between ages nine and seventeen, when sexual maturation begins.

Scrotum: Sac of skin that surrounds and protects the testicles. It is also responsible for maintaining the correct temperature for sperm to be able to live.

Semen: Mixture of sperm and fluids from the male reproductive system.

Seminal vesicles: Two glands that produce a fluid to enable sperm to swim.

Sperm: Male contribution to the making of a baby, produced by the testes.

Testes or Testicles: Two glands that produce sperm.

Urethra: Passageway through which urine leaves the body.

Vagina: The passage from the uterus to the outside of the body.

Vas Deferens: Tubes that carry sperm from the testicles to the seminal vesicles.

Vulva: External female sex organ.

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